State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anna Marie Knight DECEMBER 6:10AM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Jown, or Location of Death 4c. County of Death topoe 5. Social Security Number 7. Age (In yrs. last birthday Funeral If Under 8. Date of Birth 9. Birthplace (State or Foreign 1 ☐ M 2 🕮 Months Min. Sept. 20,1919 Days Hours Director 167-12-9182 91 Pennsylvania Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Merical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Baltimore Catonsville 1 Tes 2 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 Worthmont Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Midowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 6 Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Waters Margaret Muldoon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Knight 1514 Adamsview Road; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem. Garden 12/27/2010 Marriottsville, 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee MOIOSO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e.g. line. Approximate Interval Between Immediate Cause (Final Saysician/ OCUMO. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): sician and burial-transit resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be exec Physician/Medical the attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 1 Yes 2 Unknown 5 Other (specify) Month Year 9 Unknown signed by Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' Yes 1 Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Other: 4 \( \text{\text{Nursing Home}} \) 1 \( 5 \text{\text{\text{Residence}}} \) 1 \( 6 \text{\text{\text{Other}}} \) Other (Specify) 2 No 1 Tes မ Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Naturai (Month, Day, Year) 5 Pending To the Hospital or Attendition
 within 24 hours after death.
 To the Funeral Director: A completed filled in by the formula of the for 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Mydical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Mydical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title se of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 29 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

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			For State Registrar		State of	Marylan		ertificate of F			gien Reg. No	71111	And the second	002	
	Dharisi		1. Decedent's Nam	e (First, Middle, I	Last)					2. Date of De Month	ath Da	av Year	3. Time o	of Death	
	Physicia /Medic		Naomi		Kah1					12-26-	2010	Ď	12:3	5 A.M	
	Examin				give street and numi				r Location of Death	1	40	c. County of Death			
-	**				Nursing		land bludbala		Catonsville			Baltimore			
	Funeral Director		5. Social Security N 215-07-16 Usual Residence o	79	. Sex 7 1 □ M 2√2 F	. Age (in yrs.	Yrs.	8. Date of Bir (Month, Da 09-06-	in Year 1913	9. Birthplace (State or Fore Country) Maryland		or Foreign			
2-0030 72 hours after death with the Maryland	and		10a. State	10b. County		10c. Cit	y, Town or	_ocation		-	-		10d. Inside (	Dity Limits	
	Mary	to	MD	Carrol	1	Syk	esvil:	Le					1 ☐ Yes	s 2X No	
	r 28a	Director	10e. Street and Nu	mber			10f. Zip Code			10g. Citizen of Wha			intry?		
	23a c	ral	1919 Gard	lenia St	reet		21784				U.S	S.A.			
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. If Health and Mental Hygiene Hygiene Talens 23a or 28a-f show tem 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is likedical Evantament to a continue the continue at	by Funeral		1 ☐ Never Married 2 ☐ Married			S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	dent of Hispanic Origin? (Specify Yes or No- cify Cuban, Mexican, Puerto Rican, etc.)  2 🛣 No Specify:			14. Race - American Indian, Black, White, etc.  Specify: White			
جُ جُ	hours Tural"		3 Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education			es:	160 Doc	edent's Usual Occup				Kind of Business/l			
	in 72 n "na n edic	Completed	(Specify only highest grade completed)				(Giv	re kind of work done during most of working DO NOT use retired)		king	100.7	And of Dusinessin	idusti y		
7	filed within Hygiene. sther than " ent, II . Me	mo(	Liementary/Seco	Elementary/Secondary (0-12) College (1-4or 5+)			Seamstress			Garment					
2	al Hy fothe	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle	Maide	n Surname)				
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υ,	1 and Health em 27 ther tr		Bernice F 20a. Method of Dis	<del>-</del>	Sister	20h F		istol Hill		pt T2; (		onsville, Location - City or 1		1228	
Pages	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		1 🔀 Burial 2 4 🗆 Donation	☐ Cremation 3 5 ☐ Other (Spe		ate i	udon 1		12-3	0-2010	Ba1	timore,	Maryla		
ם מ	permit Depar Impor any In once.		21. Signature of F	uneral Service L	engke	50	3/2	22. Name and Addre	ome of Ca	tonsvil.	le.	Inc.			
			23a. Part 1. Enter	the disease, or co	emplications that car	used the deat	Do not e	1630 Edmor nter the mode of dyi	ng, such as cardiac	nue; Car or respiratory a	rrest,	sville, M	Approxima	ate	
3	hysician	6. 9	immediate Cause disease or conditi	(Final	lly one cause on each	ch line.	na	111 12 100	111				Interval Be Onset and	i Death	
	Medical		resulting in death)	DII A	a. Due to (o	r as a cons q	uence of):	unon	1 10 5		_		- cy	Lh.	
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	sit sit	ine	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease of that initiated event	nmediate erlying	Due to (o	r as a conseq	uence of):		, ,				2 (	7 '	
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00100	icate be executed physician and the burial-transit	alE				, , , , , , , , , , , , , , , , , , , ,									
00	g phy as the	edical		-	u										
O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  Where Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12	3 decedent pregnant   23c. If yes, outcome of pregnancy   1								23d. Date of deli Month	very Day	Year	
	that the ed by detac										tobacco	bacco use contribute to the cause of death?			
corus,	equires sen sign ould be	ted by								1 🗆 Y			es 217 No 3 Probably 4 Unknown		
2	e 2 sh	Completed								24a. Was	psy	24b. Were au	topsy finding completion of	s available cause of	
	icate icate , pag	S								1 ☐ Yes	2 Z N	death? lo 1 ☐ Yes	2□No		
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	siciar certif rectoi	Be	25. Was case referred to medical examiner?  Hospital:  Hospital:  Hospital:  Hospital:												
5 8	Physic rethis aral di	٠ <u>.</u>	1 ☐ Yes 2 2 27. Man → of Dea	No	1		ER/Outpat 28b. Time	ent 3 DOA	Nursing H	lome 5 Resi		6 ☐ Other (Spec	tify)		
5	nding th. :: Afte e fune	tior	1 X Natural 2 Accident	5 Pending investigat	(Month	, Day, Year)	Injury	/ Woi	rḱ? ]Yes 2. □No		,				
2	er des ector by th	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	20e. Place o	street, factory, office	treet, factory, office 28f. Location			(Street and Number or Rural Route Number,					
5	itaion insaft inaiDi	Certification:	building, etc. (Specify)  City or Town, State)												
	ne Hosp n 24 hou ne Funet pletely fil	Medical	29a. Certifier (Check o one)	2 ☐ Medical Ex	Physician: To the base caminer: On the base and manner	sis of examina	owledge, de ation and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time.	cause , date a	(s) and manner as nd place, and due	stated. to the cause	÷(s)	
i	withi To the	Ĭ	29b. Signature and	title of certifier		1		29c. Licen	se number		29d. E	ate signed (Monti	i, Day, Year)		
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	4		30. Name and add	30. Name and address of person who completed cause of death stem 23a) (Type, Print)									18		
	Sta	te	31. Date filed (Mor		1 / X Re	gistrar's Signa	ature	0 (0'	TIL	my !		INIXO	1VI		
	Registr	ar		EC 292	010 Center	m &	A. 160	ake							
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AMEND ITEM#4a, perPHYS, G910, 12/29/2010, WS

State of Maryland / Department of Health and Mental Hygiene / | | | 41003 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 2010 1:00 PMM Camilla Emilie Kelly Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death H 3641 Woodsdale Road Harford Abingdon Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Germany 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Hours Months Director 08/10/1926 84 236-50-3006 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2X No MD Harford Abingdon 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3641 Woodsdale Road - Apt. H 21009 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 □ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker <u>Own Home</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should by Department of Heaith and Mer Important: If item 27 is marke any injury or other traumatic Richard Meier Camilla Herzog 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Linda Lynne Kelly (daughter)</u> 4805 Variation Road - Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/24/2010 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 6 a 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physicians Loronary disease or condition resulting in death) ) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in the days of the cause of the ca Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 X No
9 ☐ Unknown 4 Pregnant at time of death
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an cate has b page 2 s autopsy death? perform certificate 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum\_\) Nursing Home 5 \(\mathbf{X}\) Residence 6 \(\sum\_\) Other (Specify) 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 3 [ Certifying Nurse Practiener: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0063981 12 23 2010 MD se of death (Item 23a) (Type, Print) 30. Name and address of person who completed cay 669 Revolution Benjamin Lee Havre de Grace, MD 21078 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 Amend Item 23a per dr.,g910,12/29/2010dhb Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Patrick Koehlerschmidt 7:52 a.M 2010 ecembe Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 46 City, Town, or Location of Death Examiner N/A 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Hours 2434 60 215 52 Mary land Director Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 U.S.A. 4281 McDowell Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 X Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Electric Factory Worker 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Koehlerschmidt Margaret O'Leary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Koehlerschmidt / Wife 1905 Sherwood Road Baltimore, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕱 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/16/2010 Baltimore, Maryland Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 Ritchie Highway 23a/ Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₹hysician/ espiration disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consumuence of Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed g physician and s the burial-trans Due to (or as a consequence of): Physician/Medical SUCH EXECH MIXET JAMES Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has the irector, page 2 s autopsy death? 2 XNo Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? P. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 24 hours after death.
Funeral Director: After thi leted filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 🗌 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I

complet 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier D50293 11, 2010 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMONE, MARTCANS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

2010

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		1- For State Certificate of Death		Reg. No.							
Physicia Medical Exami			2. Date of De Month Decembe	ath Day Yea er 26, 2010	3. Time of Death 1441 hrs						
		4a. Facility Name (if not institution, give street and number)  Johns Hopkins Bayview Medical Center  4b. City, Town, or Location of Death  Baltimore  4c. County of Death  Baltimore									
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 12-46-7008 1 Months Days Hours	8. Date of B Min. 6-12-		9. Birthplace (State or Foreign Country Greece						
nd ihow any ee.	Ļ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Baltimore City			10d. Inside City Limits 1 X Yes 2 No						
with the Maryland ns 23a or 28a-f show be notified at once.	Director	10e. Street and Number 10f. Zip Code 21224		10g. Citizen of Wh	at Country?						
WD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f aboundic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Divorced of Dates:  12. Was Decedent Ever in U.S.  Armed Forces? 1 Yes 2 No 1 Yes, specify Cuban, Mexican, Pull Yes, Sive Year 1 Yes 2 No 1 Yes 2 No specify:	uerto Rican, etc.)	White Specify:	White						
11215-0036 Id be filed within 72 hours Aental Hygiene, narked other than "natur event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)		Sewir							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	To Be Co		Name (First, Middle, alini Ac	griniots	5						
MD 2 and 2 shou alth and N em 27 is r		Pete Kaburopulos – Husband 525 Rappolla St.  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.		imore, N							
Baltimore, permit. Pages I an Department of He Important: If ite		1 _xBurial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:  Oak Lawn Cemetery	1-3- 11	Baltin	more, MD						
		21. Signature of Euneral Service Licensee  22. Name and Address of Facility PA, 2134 Willo	ow Sprin	ng Road	, 21222						
Physician /Medical Ēxaminer	Immediate Cause (Final disease a. Cardiac Tamponade										
cuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate course. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last									
execu an and al - tra	n/Medical	UNPENDED X AMENDED#16a,perFH,G910,12/29/2010,WS	· · · · · · · · · · · · · · · · · · ·								
Box 68760, e death certificate be the attending physici ed for use as the buri	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre 4 Pregnant at time of death 5 Other (Specify) 9 Unknown		23d. Date of o	delivery Day Year						
ires that the signed by the detached	ā	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			oute to the cause of death?  Probably 4  Unknown						
Division of Vital Records, P.O. Box 6i the Hospital or Attending Physician: The law requires that the death cert hin 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending replace in by the funeral director, page 2 should be detached for use	Completed			psy pr prmed? de	Vere autopsy findings available for to completion of cause of eath?  Yes 2 No						
of Vital Recing Physician: The free this certificate neral director, page	70 Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  26. Place of Death (Chery 1)   Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA  Other 1 No.	eck only one) ursing Home 5	Residence 6	Other:						
ion of ttending Pt leath. tor: After the funeral	cation: T	27. Manner of Death  28a. Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Work?  1 Ves 2 No 28b. Time of Injury 1 Yes 2 No		how injury occurre	d						
Division ospital or Attendia hours after death.	Certific	Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( or Town,		r or Rural Route Number, City						
Di To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and title of certifier   29c. License number		and place, and du	e to the cause(s)						
		Carol Hallan O.C.M.E.		December 2	d ( <i>Month</i> , <i>Day</i> , <i>Year</i> ) 28, 2010						
HV	╝	30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	1201								
Sta Regist	-	31. Date filed (Month, Day, Year)  32. Registrar's Signature									

DHMH 17 Rev 1/2001 OCME 2006

OCME

**ORIGINAL** 

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Many and Department of Health and Mental Hygiene 2 1 | Certificate of Death

Reg. No. State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 26, 2010 12:30P <sup>M</sup> Dec. June B. Kaine Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **E**xaminer Apt 1-B Dundalk Baltimore 130 Kinship Rd., If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) 8. Date of Birth 6. Sex **Funeral** 6-15-1940 1 🗆 M 2 🔀 F MD 70 **Director** Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County within 72 hours after death with the Maryland Director 1 Ϊ Yes 2 🗌 No Dundalk Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō pe 21222 er than "natural", or items 23a the Medical Examiner must b Funeral 130 Kinship Road, Apt. 1-B USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🛂No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H permit. Page 1 and 2 should be fili Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Ruth Woods Wilbur Kaine Donald 'S Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2117 Dundalk Ave., Dundalk, MD 21222 <del>Dondald</del> Kaine - Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ X remation 3 ☐ Removal from State Atlantic Crematory 12-28-10 Glen Burnie, 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bradley-Ashton Funeral Home 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition menute Pnysician Medical resulting in death) Due to (ir as a consequence of): Examiner eavs 0 Sequentially list conditions, as a consequence of): if any, leading to immediate cause. Enter Underlying ending physician and use as the burial-transit Cause (Disease or iinjury that initiated events requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 signed by the attending debt be detached for use as IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by diabetes 2 No 3 Probably 4 Unknown Division of Vital Records, page 2 should certificate has been endmetrial Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law I 24 hours after death. Funeral Director: After this certificate has b autopsy 2 No 1 Yes Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 1 within 2 To the 1 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1246389 and address of person who completed cause of death (Item 23a) (Type, Print) IDV , MO MO 21202 Bultimore Manony 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 29 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🛭 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 27, 8:55 P M BORIS KOLESOV 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD if Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours June 7, 1960 362-86-5552 50 Russia **Director** Usual Residence of Decedent show 10b. County filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 Kenmore Ave. 21014 UNKNOWN 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Repairman Clock Repair Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) eq pinous Boris (nmn) Kolesov (unk) Tamara (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Mary Kolesov / Wife Box 1761, Bel Air, MD 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State Hilltop Service Corp 12-29-10 4 Donation 5 Other (Specify) Towson, Maryland permit. I Signature of Funeral Service License McComas funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Encephalopath disease or condition resulting in death) Hepatic Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ute respiratori anding physician and use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No completed filled in by the funeral director, page 2 should be detached for Month Pregnant at time of death signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pendina Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) D0069413 128/10 HV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 UPBER CHESAPEAKE DRIVE BEL AIR, MO 2101L HLee

State

Registrar

31. Date filed (Month, Day, Year)

DEC 29 2010

M80047351

0100

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#17 per FH, G910, 12/29/2010, WS
State of Maryland / Department of Health and Mental Hygiene 2 | | | For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24 2010 DECEMBER SIDNEY M. KATZ 10:22 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE HOSPITAL ROCKVILLE **MONTGOMERY** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1**X**X M 2 □ F Days Hours Months 87 03/27/1923 Country) Director 072-14-4954 Yrs. NY Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD MONTGOMERY 1 XYes 2 □ No ROCKVILLE 10e. Street and Number "natural", or items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 1801 E. JEFFERSON STREET, #120 20852 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1XX Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. WHITE Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SELF EMPLOYED SEWING MACHINES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည KATZ **GERTRUDE** DEUTSCHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTELLE KATZ/WIFE 1801 E. JEFFERSON STREET, #120 ROCKVILLE, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3XX Removal from State 12/26/2010 4 ☐ Donation 5 ☐ Other (Specify) BETH MOSES CEMETERY PINELAWN, NY 21. Signature of Funeral Service Co 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiorgan -₽nysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last Staphylococcus aureus the burial-trans Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Day Year 4 ☐ Pregnant at time of death g ☐ Unknown signed by the aid Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy performed? Yes 2 W No 1 Yes 2 No Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 1 Yes 2 Ho Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Accident 24 hours after deatl Funeral Director: Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f, Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination almost investigation, in this opinion, beautiful data and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D0067386 2010 December 24. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sonia 9901 MD Medical Rockville, John Coto Dr 32. Regist ar's Sign ture State Registrar

620

01/20/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Helene Posey Physician/ Month 7 Year Vonne King 18:26 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town or Location of Death 4c. County of Death UMMC Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Sountry) 1 M 2 F Days Director Usual Residence of Decedent 10a. State 10c. City, Town or Location be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give "natural", or item ledical Examiner n 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Whit 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) If Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/S econday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Informant's Name/Relationship (Type, Print) 19b. Mailing Address<sub>i</sub>(Street and Number or Rural Route Number 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City of Town, State Date 1 Burial 2 Cremation 3 Removal from State Important: It any injury or elAir 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of rying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ hemorrhe in tra-carelo rel disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 48 hrs 1 htra - cerebrel Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi). Due to (of as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ithe Hospital or Attending Physician: The man after death.
The Funeral Director, After this certificate has been signed by the atter
The Funeral Director, After this certificate has been signed by the atternation of the funeral director, page 2 should be detached for the funeral director. 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🄁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifi 29c. License number under, MD 12859 52655 12/26/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 5 Greene St. Bultimore MO 21201 10V Tannous liver 31. Date filed (Month, Day, DEC 29 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 3 State of Many and 12 Progression of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Lee 20/0 Unknown M revontage December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Schroeder St Baltimore If Under 24 Hrs. Age (In yrs. last birthday) 8, Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 F 36 Months Days Hours Min (Month, Day, Yea Director 215-86-5546 Usual Residence of Decedent ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Exam<u>iner must be notified at</u> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b, County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral Schroeder St. USA 5. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. 1 Never Married 2 Married þ ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Kenneth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reisterstown - mother larragon Lee mo 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12-29-10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature uneral Service Licen any 23a. Part Y. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final a Chronic Kidney Onset and Death Physician Disease - Stane disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): ears iabetic ne Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine mellitus 2 ears Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Du (or as a consequence of attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetic neuropathi With 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident
3 Suicide 1 Yes 2 No Investigation 24 hours after deal Funeral Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier D0030160 (Item 23a) (Type, Print) S. Entaw St. Baltimor 30. Name and address of serson who completed cause of death 21201 rair 31. Date filed (Month, Day, Year) parke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perPHYS, G910, 12/29/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20,2010 Cleonia Motley Lewis December 1737 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery General Hospital Olney Montgomery County 8. Date of Birth 9. Birthplace (Standard Month Day, Year) 4. April 5, 1913 Virginia Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Months Days Hours Min. **Director** 97 224-18-6877 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MM 1 X Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 708 Stratford Manor Terrace, U.S.A. 20905 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Black 3 ¥ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jocephas Motley Nannie Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cephas Lewis — Son 708 Stratford Manor Terrace, Silver Spring, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛭 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Sylvannah Church Cem. 12-28-10 Spotsylvania, Virginia 21 Signature of Funeral Service Lice 22. Name and Address of FacilityRonald Taylor II Funeral Home 10583 Middleport Lane, White Plains, Maryland 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or imjury that initiated events Examiner Due to (or as a consequence of): the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Unknown 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death þ Records, To the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 Yes 2 🗖 No 4 Nursing Home 5 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director; A Investigation filled in by the Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18/01 Parce Phillip Dr Montgoney General Hospital

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dec Day 20 Physician/ Troppe Levelale 430 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 8. Date of Birth May 4, 1933 Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) 1 🗆 M 2 🕱 F Hours Director 214-30-5719 77 MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1201 Keithmont Road 21228 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes Completed by 2 🛂 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Midowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Secretary Lutheran School Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Percy Lawrence Parker Auline Chatsworth Taylor permit. Page 1 and 2 shot Department of Heaith and Important: If item 27 is m any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Lovelace Son 1201 Keithmont Road; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crematory 1 Burial 2 M Cremation 3 Removal from State 12/23/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign were Juneral Service Do June 1630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death aspiration Physician/ preumania Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending on busician and attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Cordiac avest 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cordio my opath 24a. Was an autopsy disorter performed? plastic 2 1 No 2 **N**o 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No neral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dec 20 20066 515 2010 on 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rawa

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Cay, Year, DEC 29

2010

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. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month DECEMBER 1:30p 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6645 CORINA CI COLUMBIA HOWARD Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ₹ M 2 □ F Hours Min. 070-01-4470 95 Director NEW YORK 6-19-1915 Usual Residence of Decedent or 28a-f show within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director HOWARD COLUMBIA 1 XYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6645 CORINA CT. 21044 USA or items 12. Was Decedent Ever in U.S.
Argued Forces?
1 ⚠ Yes 2 ☐ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Completed 3 X Widowed 4 Divorced Specify: BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) MASTER CHEF FOOD SERVICE Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ္ PERCIVAL LEWIS MABLE LEGGINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROGERS LEWIS (SON) 6645 CORINA CT. COLUMBIA, MARYLAND 21044 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 5 1 X Burial 2 7 ion 3 🕅 Removal from State cemetery, crematory or other place) Cremi injury o 4 Donation 5 D Other (Specify) GRACELAND CEMETERY 1-3-2011 ALBANY, NEW YORK Signature of F HIBNER 22. Name and Address of Facility REDD FUNERAL SERVICE 27 N. MONROE ST. BALTIMORE. MARYLAND 21217 23a. Part /. E, fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line.

Immediate a duse (Final disease cyrondition resulting in death)

a. Due to (or as a consequence of): Interval Between Onset and Death Physician YEUVS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Dav Year 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has auton 2 No Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 1000 Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defitying Physician is the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie

Registrar DHMH 17 Rev 7/2009 careson

2010

(Month, Day, Year)

DEC 29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARLSON

NO

32. Registrar's Signature

10700

0-53636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ LOMAS KATHLEEN LOVISE 11:10 A M De 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death HOSPITAL HOWARD HOWARD COUNTY GENERAL COLUMBIA COUNTY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2🗶 Days Hours Min Dec 28, 1940 PA Director 168-32-7268 69 Usual Residence of Decedent 10a. State 10c. City, Town or Location with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Ocean City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2401 Philadelphia Ave 21842 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", oe filed with...
Mental Hygiene.
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't, the Medical Ey 3 Widowed WDivorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retirement Home Organist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed treent of Health and Mental H rtant; If item 27 is marked ot njury or other traumatic ever Augusta Theis John Himes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 Philadelphia Ave. #126 Ocean City, MD 21842 permit. Page 1 and 2 Department of Health Important; If item 2; any injury or other t Carolyn Hooker Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial ACremation 3 Removal from State 12/28/2010 Hanover, Maryland Ardent Cremation 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facilitiarry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ a ACUTE RESPIRATORY FAILURE SECONDARY TO ASPIRATION disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** SIP LAP CHELECYSTECTOMY CHOLECARTITIE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month detached Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic pain 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autonsy perform this certificate 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Fortifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month. Day, Year) MO Mythely D0064760 Dec, 26, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYTHILY VANCHA, MD, 10710 SUITE #310, DRIVE, COLUMBIA, MO CHARTER 31. Date filed (Month, Day, Year, 32. Registrar's Signature State DEC 292010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland				Mental Hyg	iene	10	1.1015	
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	eath	2. Date of Deat	eg. No.	10	71010	
	Physicia		Robert Elmer Loomis, Sr.				Month Decembe		ďľb	3. Time of Death 2115 M	
	Medic Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County			
	<u></u>		Season's Hospice	Randallstown				Bal	timo	re	
ı	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth June 129,	Ye <b>q</b> r929	9. Birth Cour	place (State or Foreign htry) MD	
			Usual Residence of Decedent								
:	iryland I-f sho ied at	ctor	10a. State 10b. County 10c. City, To							10d. Inside City Limits 1 ☐ Yes 2 No	
	he Ma or 28a notif	Dire	MD Howard E11.	ICOU	City 10f. Zip Code		1	l 0g. Citizen of V	Vhat Cou		
	with 1 s 23a ust b	Funeral Director	9242 Marydell Rd.		2104		USA	·			
	death r item iner m		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White,	can Indian,	
036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	d by	1 Never Married 2 Married 1 Yes Alexandria 1 Never Married 2 Married 3 Widowed 4 Divorced Year or Dates.	1	☐ Yes   No	Specify:		Specify:		White	
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lan,	shoul		19a. Informant's Name/Relationship (Type, Print)	9b. Mailin	g Address (Street a		,			Code)	
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nor			Burial 2 Cremation 3 Removal from State ceme	tery, crem	atory or other place m Memori	· _ :	L.	20c. Location - arriott	-		
Baltimore,	permit. Page Department Important: I any injury or once.		21. Signature of Funeral Service Licensee			12/01	72010			y FH, Inc.	
ñ	an In Dec		John K Mynled		.2 Old Co					MD 21043	
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not ente	- 1	1		st,		Approximate Interval Between	
	Medical		Immediate Cause (Final disease or condition resulting in death)	il	Thron	n bare	e:			Onset and Death	
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л Э	that the	by Ph	Part II. Other significant conditions contributing to death but not resulting	g in the ur	derlying cause give	en in Part I.	23e. Did tob	bacco use contribute to the cause of death?			
l Sp	quires t						1 Yes 2 No 3 Probably 4 Unknown				
Vital Records,	aw rec as bee	Completed					24a. Was ar autops			psy findings available impletion of cause of	
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<u>Ita</u>	sician certifi lirector	o Be	25. Was case referred to medical examiner?   1   Yes 2   No   Hospital: 1   Inpatient 2   FB/f	0 1	Other	ce of Death (Chec		~	Los	n'CD	
0	ig Phy ter this neral d	te: To	27. Manner of Death 28a. Date of injury 28b	. Time of injury	28c. Injury	at	ome 5 Reside 28d. Describe how		r (Specify ed		
0	tendir leath. or; Afi the fur	ifica	1 Matural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	injury	M 1 □ \	Yes 2 No					
DIVISION	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  within 24 hours after death.  or the Funeral Director, After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Certificate:	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (Str City or Town,	n (Street and Number or Rural Route Number, Town, State)			
ב	ospital hours ineral d filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death o	cured at the time,	date and place, ar	nd due to the caus	e(s) and manne	er as state	ed.	
	the Ho nin 24 the Fu npleter	Med	(Check 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practioner: To the best of my kno	d/or investi wiedge, d	gation, in my opinior eath occurred at the	n, death occurred a time, date and pla	t the time, date and be, and due to the d	d place, and due cause(s) and ma	to the ca nner as st	use(s) and manner stated. ated.	
_	<b>5</b> ₩ ₩ ₩		29b. Signature and title of certifier		29c. License	number	_	9d. Date signed			
			30. Name and address of person who completed cause of death (Item 23a	(Tues P	TD/	X 10	<u> </u>	dec à	27,	2010	
	10			/ 1	a b'in	Blus	Cui	to A	1 2	2010	
	Stat Registra		31. Date filed (Month, Day, Year)  DEC 29 2010  32. Registrats Signature		,			(			
	negistra		HEL GOLUIU LEGUET P								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #21 Per. FH G911 1/05/2011 TH. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Louise C. Lewis 12-23-2010 815 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2217 Kempton Park Circle Bel Air Harford 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10–30–1938 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Months Days Hours Min. 219-26-5395 72 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f sh Director 1 ☐ Yes 2 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or minortant: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the World Evan in an autobac ange. 2217 Kempton Park Circle Funeral 21015 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: ģ 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hair Dresser Hair Dressing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis J. Gosewisch ပ Catherine Silberzahn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Bowers (Daughter) 2217 Kempton Park Circle Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 12-31-2010 Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd Bel Air, MD 21014 Brian D. Lewis per DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage 5 mall **Physician** disease or condition resulting in death) /Medical Due to (gras a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): law requires that the death certificate be executed burial-transit Exami and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 mont Month Day Year signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 icate has been siç , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Triknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 □Yes 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After t 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending | within 24 hours after death. To the Funeral Director: After 1. Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date sighed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 1.35 Salvatore (nmn) LoPresti Medical DE 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BELAIR BELAIR NEALTHAND REHABYLITATION CENTER HRAFORD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 XM 2 🗆 F Months Days Hours Min (Month, Day, Year) New York Director 055-20-7199 Aug. Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Marvland Harford 1 Yes 2 No Churchville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a ortant: If item 27 is marked other than "natural", or items 23s injury or other traumatic event, the Medical Examiner must I 215 Olde Beau Court 21028 USA 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Hygiene. other than "natural", or i Black, White, etc. 1 Never Married 2 Married Completed by Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Microbiologist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gaetano (nmn) LoPresti permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Benedetta (nmn) D'Antona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Olde Beau Court, Churchville, MD 21028 Peter IoPresti / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burjal 2 🗆 Cremation 3 🗔 Removal from State 4 🗆 Conation 5 🗐 Other (Specify) Harford Memorial Gdn. 12-24-10 Aberdeen, Maryland e of Funer 21. Signa <sup>22. Name and Address of Facility</sup>
MCComas Funeral Home, P.A.
50 W. Broadway, Bel Air, Maryland 23a. Part 1. Enter the disease, or complication s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metastatic (primary unknown bone. cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of, resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death Year P.O. I s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? theimer's dementia Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page 2 has autopsy autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) 2 No မ 1 🗆 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be s after death filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier within 24 hor To the Fune completed fi 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 12/22 Y 006398 MD 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin Lee Revolution St. 669 31. Date filed (Month, Day, Year) 32. Registrar's Signature State UEC 2 9 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 23, 2010 Physician/ Lockard 11:05 AM Thomas Ray Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3523 A Scarboro Road Street. Harford If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday, **Funeral** (Month, Day, Year) ar. 23, 1940 Months Days Hours Min. Country) Virginia 1**X** M 2 □ F Director 215-34-8391 70 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hant: If item 27.5 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at oury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No Harford Maryland Street 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 3523 A Scarboro Road 21154 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 N Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Manufacturing Assembly Line Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances (unk) (unk) Warren (unk) Sturms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy A. Vaartjes / Daughter 3523 Scarboro Road, Street, MD 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it 🛮 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 12-28-10 injury Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn 22. Name and Address of Facility
MCComas Funeral Home, P.A.
50 W. Broadway, Bel Air, MD 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death una Immediate Cause (Final Cancer all Physician disease or condition resulting in death) Medical Due to (or as a onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy atten in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy perforn 1 ☐ Yes 2 ☐ No Yes 2 Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5  $\square$  Pending within 24 hours after death.

To the Funeral Director: Af Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certific 29d, Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)
DEC 29 2010

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

MI

602 S. Atwood Road

Bel Air, MD 21014

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#4a, perphys, G910, 12/29/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 2010 7:53 PM **JAMES** LEVIE Medical 4a. Facility Name (if not institution, give street and number)
1926 Greengage Road
ATHELAS INSTITUTE 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Days Hours 1070 Py 1946 214-72-9007 64 MD Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho dical Examiner must be notified at death with the Maryland Director 1 Yes 2 X No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1926 GREENGAGE ROAD 21244 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give 1 X Never Married 2 Married ş Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. Specify. 3 Widowed 4 Divorced WHITE Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) NONE NONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ၉ MAURICE F LEVIE RUTH MALESON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH LEVIE/MOTHER 7121 PARK HEIGHTS AVE, #303, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CEMETERY 12/24/2010 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matt Co 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Sigha mous (archowa f Hysician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): sician and burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be execu-Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 No s been signed by the standard should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 XNo 24a, Was an cate has l autopsy performed? Yes 2 this certificate 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 🗌 Nursing Home 5 🕰 Residence 6 🗌 Other (Specify) Hospital: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 1 Naturai 5 Pending injury within 24 hours after death.

To the Funeral Director: All completed filled in by the fi 2 No 1 Yes 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 23, Occember MY 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. C 2120 hoples (well 31. Date filed (Month, Day Year) State 9 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 2010 6:15 P M LIBERMAN BRONISLAVA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BALTIMORE MILFORD MANOR NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 M 2 X Days Hours Min 07/24 1925 Months 85 UKRAINE 218-63-6937 Director Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director filed within 72 hours after death with the Maryland must be notified 1 Yes 2X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 4204 OLD MILFORD MILL ROAD, #207 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. or Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. WHITE Specify: "natural", 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **EDUCATION** TEACHER traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental .. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked o ျ GREGORY RUBAN SARAH KANEVSKIY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SVETLANA SPICHINEVSKIY/DAUGHTER 2429 LIGHTFOOT DRIVE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ö 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 12/29/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as rardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Betweer Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Dissilto for es a nonsequenne offi cause, Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death 9 Unknown Unknown P.O. Part II. Other significant conditions to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No မြ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) f Death 27. Mann 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Director: / Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral D Certifying Physioian: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Exam On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse P actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific

Registrar
DHMH 17 Rev 7/2009

30. Name and address

leted cause of death (Item 23a) (Type, Print)

Alle

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ PHYLIS MARGOLIES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3909 BRYONY ROAD BALTIMORE RANDALLSTOWN Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 1 M 2 XF 1070471939 217-34-6864 71 PA **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 TNo BALTIMORE MD RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3909 BRYONY ROAD USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify. Completed 3 XWidowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) SOCIAL SECURITY Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) EXAMINER ADMINISTRATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HERBERT MARGOLIES MILDRED HARRISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN NICKELSON/DAUGHTER 44 STONE DRIVE, PASADENA, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 NBurial 2 Cremation 3 Removal from State EMUNAH AITZ 4 Donation 5 Other (Specify) 12/26/2010 BALTIMORE, MD 21. Signature of Funeral Service Licer SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac Approximate Interval Bely shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year sate has been signed by the page 2 should be detached g Unknow q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DADYOM XOP No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be ( 26. Place of Death (Check only one) Hospital: Other: <u>ء</u>| 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28c. Injury at work?
1 Yes 27. Manner of Dea Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 □ 29d. Date signed (Month. Date 10

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State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Lewis 8-32 am 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A HUBOR Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth
(Month, Day, Ye
Sept. 14. 1 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 1 M 2 - F Director 217-34-2832 73 Sept Virginia Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 ☐ Yes 2 No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 243 9th Street 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black White etc. <u>م</u> 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bethlehem Steel Elementary/Seconday (0-12) 10 **Pipefitter** Sparrows Point Shipyard and Mental Hygie is marked other of Health and Mental Hygin of Health and Mental Hygin Fitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marion Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other the Patricia A. Lewis (Wife) 9th Street, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Dec. 30th 2010 Marriottsville, Maryland Crestlawn Mem. Gardens 21. Signature of Eugeral Service Lice 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road Pasadena, Maryland 21122 oft 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preumonia disease or condition days ) Medical resulting in death) Examiner Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine as a consequence of requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical My potentian Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by [cooxy Artery disease] Records, Completed 1 Yes 2 No 3 Probably 4 Unknown [ Chronic obestructive lung disease] 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 INo Yes 22 No the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital 1 Tes Other: ဂ္ Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

le Funeral Director: Afte bleted filled in by the fun 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed To the I within 2. 29b. Signature and title of certifier Hegagn Maraa RES OOI pecenber, 27.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Murula Hegagir 6418 CENTENNAL CIN Circle Apr B. 21061 . Glen burne Maria 31. Date filed (Month, Day, Year) State Registrar

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			For State	State of Mar	yland /	•			ind Mental I	Hygier	ne 201	0 1100	
			Registrar  1. Decedent's Name (First, Middle, L	ast)		Certific	ate of L	Jeath	2. Date of	Reg. I		3. Time of Death	
	Physicia Medic		Lisa Lynette Moon	,					Month	nner	Day Year これ 知り	10:00	
0	Examin		4a. Facility Name (if not institution, gi	ve street and number)	more		ity, Town, o CUH N	r Location of			4c. County of Dea		
	Funeral Director			Sex 1 M 2 4 7. Age (/ 39	'n yrs. last b	yrs. If Ur Mont	hs Days	If Under 2 Hours	Min. 8. Date of (Month)		1971 Mar	irthplace (State or Foreign ountry) Y Land	
	yland f show ed at	tor	10a. State 10b. County	1	0c. City, To	wn or Location						10d. Inside City Limits	
14 NOTE OF THE O	e Mar	Direc	Maryland N/A  10e. Street and Number		Balti		Zip Code			T		1 ₹ Yes 2 □ N	
S S	with th	Funeral Director	3414 Dofield Aver	nue # 122		101.	21215	;			Citizen of What C	ountry?	
ograda Ograda	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at.	þ	11. Marital Status 1 ★ Never Married 2 ☐ Married	12. Was Decedent Eve		If Yes, s	cedent of H	ispanic Orig in, Mexican,	in? (Specify Yes or Puerto Rican, etc.)		14. Race - Am Black, Whi	te, etc.	
9	ours al	eted	3 Widowed 4 Divorced  15. Decedent's	Year or Dates.	1.47	6a. Decedent's U				11	Specify: Bla		
45 LES	in 72 h e. nan "na Medic	Completed	(Specify only highest Elementary/Seconday (0-12)	grade completed)  College (1-4 or 5+)		(Give kind of life. DO NOT	work done	during most	of working	16b	. Kind of Business	s Industry	
2	d with lygien ther th	Be Co	11th grade			Homema	ker				wn Home		
Maryland	be file ental h ked o ic eve	To E	Lee Moore	t)					r's Name <i>(First, Mid</i> r <b>inia A.</b> S				
ary S	should and M is mar	3	19a. Informant's Name/Relationship	(Type, Print)	1	9b. Mailing Add	ess (Street		or Rural Route Nu			(ip Code)	
	and 2 s lealth s em 27		Virginia A. Falo	con/ Mother				d Aven	ue #122 I				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical ODGE.		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		ceme	e of Disposition ( etery, crematory Mount Car	or other plac		Date 2/29/2010	- 1	Location - City o		
3alti	permit. F Departm Importa any inju		21. Signature of Funeral Service Lic		<del>alai</del>	22. Name	and Addre	ss of Facility	Chatman-	Harr	ris Funer	ral Home	
	<u> </u>		23a. Part 1. Enter the disease, or co	mplications that caused th	ne death D				wn Road I		more,MD		
	Physician/ Medical		shock, or hear failure. List only immediate Cause (Final disease or condition resulting in death)	one cause on each line.  _a. Acute Re	espiro	atory D	istres		ndrome	y arrest,		Approximate Interval Between Onset and Death  OWEEKS	
-	Examiner			Due to (or as a c	onsequenc	e or):							
	sit d	Examiner	Sequentially list conditions, cause. Enter Underlying	Due to (or as a c	ur sequi nn	of)							
	certificate be executed nding physician and use as the burial-transit	Exar	Cause (Disease or linjury that initiated events resulting in death) Last	c Due to (or as a c	onsequenc	e of):							
90	te be e nysiciar ne buri	edical		<b>d</b>									
3876	ertificat ding ph e as th	/Mec	IF FEMALE:	23c. If yes, outcome of	progranav							1	
Box	death he atte ed for	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1  Live Birth 2   4  Pregnant at ti	🗌 Fetal de	ath 3 ☐ Ectop n 5 ☐ Othe	oic pregnand (specify) _	ру		_	23d. Date of d Month	elivery Day Year	
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rds,	equires een się rould b	ted t									Yes 2 □ No 3 □ Probably 4 □ Unknown		
eco	rsician: The law requires that the certificate has been signed by the director, page 2 should be detach	Completed	Dicibetes 24a. Was an autopsy performer								24b. Were autopsy findings available prior to completion of cause of death?		
a B	ian: Th rtificate stor, pa	Be C	25. Was case referred to medical 26. Place of Death (Check only one)								No 1 ☐ Yes 2 ☐ No		
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o u	nding F tth. : After 1 : funera	cate:								be how in	njury occurred		
Division of Vital Records, P.O.	l or Atter after dea Director	Certificate:	3 Suicide 6 Could no determine	be 290 Plane of Injune	ury - At home, farm, street, factory, office 28f, Location /Stree						eet and Number or Rural Route Number, State)		
П	To the Hospital or Attending Physician: "In this 24 hours after death and the Funeral Director; After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Exa	nysician: To the best of my miner: On the basis of exar urse Practioner: To the be	mination and	d/or investigation	in my opini	on, death occ	curred at the time, da	ate and pla	ace, and due to the	e cause(s) and manner stat	
	To To 1		29b. Signature and title of certifier	Darlo 9	→ MD		29c. Licens RE	e number	00		Date signed (Mon Cemper	ith, Day, Year) QQ, QOIC	
1			30. Name and address of person wh	o completed cause of dear	th (Item 23a	a) (Type, Print)	ital	of f	Saltimon	0.			
Ų,	Sta	te	31. Date filed (Month, Day, Year)  DEC 29	32. P gistrar's	Signature	Hosp	1190	- 1		<u> </u>			
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Lisa Lynette Moore

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Posticent Known

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MUNSON Physician/ القيح 1220 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Mandrin House Harwood If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) Social Security Number **Funeral** Months Days Hours Min. 1 DM 2 1 "192<u>5</u> Washington, DC Director 85 579-20-6885 Usual Residence of Decedent Department of Health and Mental Hygiene. Insture!"

Important: If item 27 is marked other than "nature!"

any injury or other traumatic events. 10d. Inside City Limits 10a, State 10b County 10c, City, Town or Location Director 1 Yes 2 X No Maryland Calvert North Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 4001 10th Street 20714 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. ð 1 Never Married 2 Married Yes 2 X No Specify: White 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Kate Elizabeth Bailey Louis Decker Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Irvington, AL 36544 8650 A Major Maples Road Joseph F. Sullivan/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 XCremation 3 ☐ Removal from State Final Journey Crematory 12/27/2010 Woodbine, Maryland 4 Donation 5 Other (Specify) e of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Homas anuto M00957 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ACCIDENI Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death g 🗌 Unknown should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has perform 2 🗌 No 1 Yes 21 Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After injury 1 Natural 5 Pendina 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) TEFENSE HWY, ANDAPOLIS, M.D. 21401 IGHT FOOT TAYLOR JENEVIEVE

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Registrar

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death DEC Physician/ 2212 M MCCLINTON HELEN 2010 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death 4h. City **Examiner** Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year, 06-26-193) Months Hours Min 1 🗆 M 2 😾 F Missouri Director 496-32-1577 Usual Residence of Decedent 10d. Inside City Limits 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10c. City, Town or Location Funeral Director 1 Yes 24 No Hanover MD Anne Arundel 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code United States 21076 7432 Hickory Lane 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Ves 2XXNo Specify: Specify White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ (Unavailable) (Unavailable) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7246 Forest Avenue, Hanover, Maryland 21076 John L. McClinton, Jr.- son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition txx Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Park | 12-31-2010 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kuafman Funeral Home at 21. Signature of Funeral Service Ligensee MMP., Inc, 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aortic Stenosis Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner Due to (or as a con-Quence of) cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 1 🔲 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 29b. Signature and title P19685 2010 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St. Baltimore, MP Thomas M Pembroke. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 30 PM MAY DEC CLARA 3 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE UTURB CARE COURT COUNTY OLD If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Days Hours | Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 20 F Months Director -18-2247 FLURIDA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No BALTIMORE RANDAllstown Director MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5412 U.S.A. RUAD OLD COURT 21133 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BEAUTICIAN HAIR DRESSER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) UNK NEWN Be 19a. Informant's Name/Relationship (Type, Print) KATIE BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1302 Sudvale ROAD, PIKESVIIE, MARY JAND 1302 ANTHONY STOKE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 28/2010 BALTIMORE, MARYLAND CREMATORY INC. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. JONES FH. P.A. 22. Name and Address of Facility ThE DERRICK MARYLAND sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that assed the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) THERO SCLEROTIC CARDIOVASCULAR DISEASE **Physician** YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dua to for as a consequence of: death certificate be executed Due to (or as a consequence of): use as the burial-Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medicai IF FEMALE: IF FEMALE:
23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) detached cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably MYELOMA 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature, and title of certifier DEC 28 asanthalcum MI) 425 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TUA icuman ROLLINGRD # 108 MD21220 516. N. 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2, Date of Death Physician/ 7937 AM ward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Months Days Hours 11/25/1945 Country) Director 214-44-5171 65 MD Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 USA 970 Magothy Avenue 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. should be filed within 72 hours after cand Mental Hygiene.

is marked other than "natural", or 1 Never Married 2 XMarried þ Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Claims Adjustor Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) McLoyed Matkins, Sr. Dena Kunaras age 1 and 2 should bent of Health and Mer it: If item 27 is marker y or other traumatic Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kathleen E. Matkins/ wife 970 Magothy Avenue Arnold, MD 21012 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit, Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ♣ Other (Specifientombment Glen Haven Mem. Park 12/29/2010 Glen Burnie, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mous disease or condition Medical resulting in death) Due to (or as a consequen Examiner yeur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det þ Records, The law requires 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) No ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 atural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Eertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Mirza M. Nusairee M.D. 1401 Madison Park Suite#100 Glen Burnie, Md 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛴 📗 📗 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Matouic 2010 01.30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Regional George Hospita aurel 9. Birthplace (State of oreign If Under 24 Hrs 8. Date of Birth Funeral 7. Age (In yrs 1 M 2 XX April 23, Months Hours Country) 165-26-1707 77 **Director** 193 Usual Residence of Decedent 28a-f shov 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Prince George 1 X Xes 2 No Laurel 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? event, the Medical Examiner must be Funeral 23a 15311 Alan Drive 20707 U.S.A. items ; 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XX If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) than " University of Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. vear Secretary Maryland is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Henry Ford Susan Dupont Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other tra Shirley F. Abatta sister Laurel, Maryland 15311 Alan Drive 20707 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State 12/27/2010 Arundel Crematory 4 Donation 5 Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility
Donaldson Funeral Home, P.A. Lig-M00770 313 Talbott Avenue Laurel Maryland 20707 23a. Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. L st only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Respirator Medical s a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as a consequence of Exami Severe Dementia for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death To the Hospital or Attending Physician: The law requires that the des within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 I Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ပ 1 🔲 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No. 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis or examination and or investigation, in my opinion, south the date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. D70093 0 7300 Van Dusen Road Laurel, Maryland 20707 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible ink Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death mae E. Macke Month 7 Physician/ Year 7:45 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b: City, Town, or Location of Death 4c. County of Death Examiner Baltimune If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth NC inplac **Funeral** 1 M 2 F Days ADTUI & Months Hours Min Yrs. -MD Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore N/A M Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2745 Beryl Ave 21205 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: Black Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'a any injury or other traumatic event, the Meonee. Elementary/Seconday (0-12) College (1-4 or 5+) Finance Dept Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John McLendon Mary McLendon 19a. Informant's Name/Relationship (Type, Print)
Dana Mackey/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Meadow Lane, Waldorf, MD 20601 20c. Location - City or Town, State Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 12/30/10 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cem. 4 Donation 6 Other (Specify) 21. Signature of Fureral Service Licenses 22. Name and Address of Facility Hari P. Close F.Svs,PA 5126 Belair Rd,Baltimore,MD 21206-51 05 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. cell Immediate Cause (Final disease or condition resulting in death) Onset and Death Non Physician/ 8mall Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to jor as a consultence of cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 62 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ₺ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No. 1 Watural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ROUSIN amolh December 27,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1650 Orleans St. CRS1-186, Baltimore, MM 21231 ROISIN CONHOLLY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2.9 2010 Registrar

John

William

Baltimore, Maryland 21215-0036

Box 68760 P.O. Division of Vital Records. After this

4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Future Care North Point Baltimore Dundalk 8. Date of Birth (Month, Day, Year)
July 28,1922 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months 1 M 2 □ F 215-18-8057 88 Yrs. Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show the Medical Exprisher must be notified at Md. Baltimore Dundalk 1 ☐Yes 2 No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 2415 Plainfield Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Macany injury or other traumatic event, the Macany once. Elementary/Secondary (0-12) College (1-4or 5+) Welder Bethlehem Steel 9 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul L. Mantheiy Helen Mary Hogan P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2415 Plainfield Road, Dundalk, Md. 21222 Wife Vada Mantheiy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Middle River, MD. Holly Hill Memorial 29, 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund <sup>22. Name and Address of Facility</sup>
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 21222 wo Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show the heart failure. List only one cause on each line. Immediate Cause (Final Och Physician un- Krown disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sunsequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I □Yes 2 □No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔽 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12-24-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709. BASTERN BLUD, MALIKA NASREM. 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

Mantheiy

State of Maryland / Department of Health and Mental Hygiene 🚄 🖯

2. Date of Death

December

Day

24,

2010

3. Time of Death

2:10 a M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marie McClary Month 8:100 December Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ARBOR HOSPITAL BALTI MORE N/AIf Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Months Hours Min JUNE I 1949 MARYLAND Director 218-46-9701 61 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director XXYes 2 ☐ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3018 SOUTHLAND AVENUE U.S.A. 21225 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 ☐ Married þ Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates "natural", Specify: BLACK Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SOCIAL SECURITY ADMIN 12th grade CLAIMS REP. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ NATHANIEL A McCLARY ANNIE M WILKENS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i 1233 N. Central Ave., Baltimore, Md., 21202 Romaine Hargrove/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot Date 1 XXurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL 01-03-2011 BALTIMORE, MARYLAND 21. Signat of Funeral Service Ligensed 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE New Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Gastro intestinal bleeding hours Medical Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury equires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical P.O. Box 68760 ţ, use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? reen signe should be d Sewer pulmonary Hypertension Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Coranary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas I autopsy Interstitial June DISCASE erformed? te 2 No 1 🔲 Yes After this certific Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work 24 hours after death. Funeral Director: A 2 Accident 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho
To the Fune 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signat 29d. Date signed (Month, Day, Year) Mani RES 00 DECEMBER , 24 , 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDULGHANI SAADI 3001 South Hanover Street, Baltimare, MD, 21225 OV

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day,

DEC 29 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Decembe 12:45P M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore B Glenwood Rd.. Essex 8. Date of Birth (Month, Day, Yea May 23 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 N F Days Min. Months Hours Director 86 Yrs 217-18-6442 1924 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified. 1 🗆 Yes 🏞 No MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21 B Glenwood Road 21221 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify. Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0wn 7 Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Rudolph Vanko Marie Neubert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janowitz /Daughter 346 George Avenue Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Dec 23 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2010 21. Signature of Funeral Service Licensee M0144B 22. Name and Address of Facility Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner erosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) ysician and e burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 nding parse as t IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Day Pregnant at time of death Month Year 1 Yes 202 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 **N**o ၉ 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier State Registrar

X DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Is. McVicker Nadine Phyllis 2010 December 5:40 AM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's Laurel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Feb 5, 1933 1 □ M 2 🖵 F Min Months Days Hours 271-30-5866 76 Salem, WV Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Ellicott City 1 Yes 2 No Howard 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 4734 Woodland Road USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates White 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Underwood Edith Mae Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bradley McVicker - Son 33 North Street LeRoy, NY 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 12-23-2010 LeRoy, NY 4 Donation 5 Other (Specify) Machpelah Cemetery Cameron Funeral Home 21. Signatura f Funeral Service Ligensee 22. Name and Address of Facility 26 Rochester St. Scottsville, 14546 NY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock/or heart fallure. List only one cause on each line. Approximate Interval Between mediate Cause (Final Onset and Death Congestive Heart Failure disease of condition resulting in death) Due to (or as a consequence of): Metastatic Malignancy Due to for as a consequence of Coronary Artery Disease Due to (or as a consequence of)

Physician Medical Examiner

and -tran

the

signed by

has

eral Director: After this certificate I filled in by the funeral director, pagr

within 24 hours a

the burial attending physician

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

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Certificate:

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**Funeral** 

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within 72 hours after

Baltimore, Maryland 21215-0036

ıral", or items 23a or 28a-f shor I Examiner must be notified at

"natural",

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permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th

the Medical

Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? g 🗌 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Pregnant at time of death
Unknown

23d. Date of delivery Month

26. Place of Death (Check only one)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown 24b. Were autopsy findings available prior to completion of cause of

death?

29d, Date signed (Month, Dav. Year)

Year

Day

25. Was case referred to medica examiner? 2 ☐KNo 27. Manner of Death

29b. Signature and fittle of certifier

1 XNatural

Accident Suicide

4 Homicide

1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 5 Pending Investigation 6 Could not be

4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at injury work' 1 Tes 2 🗌 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other:

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

autopsy

☐ Yes

29a. Certifier (Check 3 🗌 only one)

determined

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

completed cause of death (Item 23a) (Type Print)

7300 Van Deusen Road Laurel, MD

State Registrar

D70093

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day KATHERINE MOORE 6:00 December 24 рΜ 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard 3697 Sharp Road Glenwood Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗷 F Months Days Hours December Director 212-40-0629 69 Maryland 1941 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Howard **Glenwood** 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21738 U.S.A. 3697 Sharp Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 😿 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give 3 K Widowed 4 Divorced Year or Dates 15. Decedent's Education . Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. conday (0-12) College (1-4 or 5+) Seamstress Clothing Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Milleker Louise Wise t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 2201 Fire Thorn Road, Middle River, Maryland 21220 Sandra F. Clark 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park injuny Dec. 29, 2010 Glen Burnie, Maryland Signature of Funeral 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Interval Between I neglate Cause (Final ris se or condition retting in death) Onset and Death Physician. CUMCIA Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, and a cause. Enter Underlying Cause (Disease or iinjury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ÞÁìo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy perform 2 No After this certificate 10 1 Tyes Be ( 25. W case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 X No မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending injury Accident work?
1 Yes 2 No within 24 hours area \_\_\_ Af To the Funeral Director; Af Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my calcium death. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

Registrar

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State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

6

9 2010

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Year CATHERINE M. MELTON December 7:00 рм Medical 4b. City, Town, or Location of Death
Baltimore 4c. County of N/A 4a. Facility Name (if not institution, give street and number) **Examiner** Harbor Hospital Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) August 12, 1913 1 🗆 M 2 🗷 Days Hours 212-14-9733 97 Director Mary land Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A 1 ☑ Yes 2 ☐ No South Baltimore 10e. Street and Number 10g. Citizen of What Country? by Funeral 1546 Boyle Street 21230 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Salesperson Hutzler Brothers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Williamson Catherine Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Weigman (Grandaughter) 1546 Boyle Street, Baltimore, Maryland 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Dother (Specify) Cedar Hill/Cemetery Dec. 28th, 2010 Brooklyn Park, Maryland . Signature of Funer ervice Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Interval Between Onset and Death mediate Cause (Final Physician/ resulting in death) Medical Examine VASCULAR DISFASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in the later of the l Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available 24a. Was an autons prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

DHMH 17 Rev 7/2009

State

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 7:50 P David J. Nephew December Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Randolph Hills Nursing Home Wheaton Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country Michigan 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours Min sept 5, <sup>Ye</sup>¶926 84 363-28-5236 Yrs Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18003 Mateny Road, Apt #420 20874 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ò þ 1 Never Married 2X Married 1 X Yes 2 □ No If Yes, Give Year or Dates 1944–46 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural" Completed 3 Widowed 4 Divorced White 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Heavy Equipment Operator Construction traumatic event. Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is meany injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 David Nephew Loretta Voodre James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene L. Nephew/wife 18003 Mateny Road, Apt #420 Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Journey Crematory 12/23/2010 Woodbine, Maryland 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Thomas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician disease or condition Coronary Artery Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Day Year signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 No certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No Other: မြ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this in by the funeral dir 4 X Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natura 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation in my original death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) creter D0064624 December 22, 2010

State Registrar

DHMH 17 Rev 7/2009

743 Summer Walk Drive

ask

32. Registrar's Signature

Gaithersburg, Maryland 20878

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sandeep Sharma, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of Ma	aryland /			of Health		Mental H	ygien Reg. N	71111	41037
	Dhysicia	/	Decedent's Name (	First, Middle, Las	st)						2. Date of D	eath		3. Time of Death
	Physicia Medio		Stuart	David				,			Decem	ber [	26, 2010	2:15 P M
	Examin	er	4a. Facility Name (if no		street and number)				own, or Locatio			4	c. County of Deat	
	Funeral		6410 Maide 5. Social Security Num	en Lane nber   6. Se	ex 7. Age	e (In yrs. last bii	thday)	If Under 1	ethesda Year If Und	ler 24 Hrs.	8. Date of B	irth	Montgo	mery thplace (State or Foreign
	Director		041-18-94	4	<b>X</b> M 2 □ F	90	Yrs.	Months	Days Hours	Min.	(Month, I	2, Year)	920 Con	necticut
7	t oo	L	Usual Residence of De 10a. State 1	ob. County		10c. City, Tov	n or Lo	ecation						10d. Inside City Limits
200	arylar a-fst ified a	ecto	Maryland	Montgo	merv	100. 01.9, 101		hesda						1 ☐ Yes 2x No
A cq	or 28	Dir	10e. Street and Numb					10f. Zip C	Code			10g. C	Citizen of What Co	
145.45	s 23a nust b	Funeral Director	6410 Ma	aiden La	ne			20	0817				United	States
4000	ritem ner m		11. Marital Status		12. Was Decedent E Armed Forces?		13. \	Was Deceder If Yes, specify	nt of Hispanic ( / Cuban, Mexic	Origin? (Spe an, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, White	
0000	al", ol	d by	1 Never Married 3 Widowed 4		1 X Yes 2 If Yes, Give Year or Dates 1 9			1 🗌 Yes 2	⊠No Speci	ify:			Specify:	
5	natur lical B	lete		15. Decedent's Ed	ducation		a. Deced	dent's Usual (	Occupation			16b.	W Kind of Business	hite Industry
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	sntal H ked o c eve	일	John	Philip	Nelson				I .	ther's Nam Mary	e (First, Middle Evel		Erickso	n
בי ב <u>י</u>	ond Me		19a. Informant's Name			19	b. Mailir	ng Address (S					or Town, State, Zip	
<b>Y</b>	alth a n 27 is		Cynthia Ne	elson/da	ughter			,	. Vrain					gs, CO 80904
ב ב ב	of He If item		20a. Method of Dispos		Removal from State	20b. Place o	of Dispo	osition (Name matory or othe	of er place)		Date	T	_ocation - City or	
	tment tant: rigury o		4 Donation 5	Other (Specif		Final 3								Maryland
	permit, rage I and a storous be first within 72 thous after death with the wallyfail of permit, rage I and a storous be first within the Medit and Mental Hygier I in marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign were of Funer	$\mathcal{L}$	Roma	M00957	GC Be	Name and A	Address of Fac DME Crei	matio krott	n Serv	ice l	P.O. Box	784 e, MD 21029
			23a. Part Enter the	disease, or comp		the death. Do	not ente	er the mode o	of dying, such a	as cardiac	or respiratory a	arrest,	11.120	Approximate Interval Between
₽ł	hysician/		Immediate Cause (Fir disease or condition		Complic		of	Conges	stive H	eart	Failure	9		Onset and Death
J.	Medical xaminer		resulting in death)	C	Due to (or as a	consequence	of):							
		er	Sequentially list conditions, if any, leading to immediate  b. Arrythmias (Cardiac)  Due to (or as a consequence of):											vears
pe	nsit	Ē	if any, leading to imme cause. Enter Underlyi Cause (Disease or iinj	ng 💮	Due to (or as a	consequence	01).						1	
execu	in and ial-tra	Ex	that initiated events resulting in death) Las	st	Due to (or as a	consequence	of):							
cate be executed	physician and the burial-transit	edical Examiner	d											
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ath ce	attending p I for use as t	Physician/N	23b. Was decedent pro in the past 12 mo	nths?	23c. If yes, outcome of 1 ☐ Live Birth : 4 ☐ Pregnant at	2 🗌 Fetal dea		Ectopic pre					23d. Date of del Month	ivery Day Year
the de	by the	hysi	1 Yes 2 1 N	40	9 🗆 Unknown									
that	gned b	by P	Part II. Other significa		ontributing to death bu	ut not resulting	in the u	ınderlying cau	use given in Pa	rt I.	23e. Did	tobacco	use contribute to	the cause of death?
duires	en sig		Dementi	.a	4-7-						1 🗆	Yes 2	No 3□Pr	robably 4 Unknown
law requ	as be	Completed										opsy	prior to d	copsy findings available completion of cause of
The T	cate ;										1 🗌 Yes	formed? 2 XN	death?	2 🗌 No
sician	certif	) Be	25. Was case referred examiner? 1 ☐ Yes 2 🛣	196	Hospital:				26. Place of De			_		
Phys	er this	e: To	27. Manner of Death		28a. Date of injur		Time of		. Injury at		me 52 Res 28d. Describe		6 Other (Speci ry occurred	f(y)
endin	or: Aft	ficat	2 Accident	5 ☐ Pending Investigation		, rear)	injury	M	work?	□ No				
or Att	fter de irecto n by t	Certificate:	3 ☐ Suicide 6 4 ☐ Homicide	6 LJ Could not be determined	28e. Place of Inju building, etc		arm, stre	eet, factory, o	office		28f. Location City or To		nd Number or Rur	al Route Number,
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e Hos	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2	Medical Exami	sician: To the best of a ner: On the basis of ex se Practioner: To the b	amination and/	or invest	tigation, in my	opinion, death	occurred at	the time, date	and place	e, and due to the o	ause(s) and manner stated.
To th	within To th comp	~	20h Cianatura and title	of cortifier					icense number				ate signed (Month	
			Mic	lul &	2 Puts	lo U	1		D002111	19		Dec	cember 27	7, 2010
1	/		30. Name and address	of person who c	ompleted cause of de	eath (Item 23a)								
,	Stat		<ol> <li>Date filed (Month, I</li> </ol>	Day, Year)	M.D. 21	12 F St	ree	t, Sui	te 603,	. Wasl	ningtor	, DC	20037	
	રાકા Registra		DEC 29	2010	32. Registra	1. Sac	M							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles Ernest Nichols, III 6:00 AM December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George Doctors Community Hospital Lanham Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1₺ M 2 □ F Days Months Hours Min.  ${
m March}^{(Month,Day}1^{{
m Year})}1926$ 84 Yrs. Director 216-18-0682 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD 1 XYes 2 ☐ No Prince George Laurel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 906 Nichols Drive 20707 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 E Yes 2 No 1944-11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: Specify: white "natural", Completed 3 X Widowed 4 Divorced 1946 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) District of Columbia than Elementary/Seconday (0-12) College (1-4 or 5+) Locksmith Government Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Charles Ernest Nichols, Jr. Page 1 and 2 should be ment of Health and Ments Helen Askins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Ernest Nichols, IV/Son 6198 Bob Horsey Road, Marion Station, MD 21838 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State St.Mary's Cemetery 2010 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. 22. Name and Address of Facility Stein: 313 Talbott Ave., Laurel, MD 20707 M01053 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to o as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been sinned by the attanding abusing a second burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No the page 2 should be detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? Director: After this certificate Yes 1 Yes completed filled in by the funeral director, 25. Was case referred medical 26. Place of Death (Check only one) Hospital 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) May er of Debth 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No atural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number 64268 and address of person who completed cause of death (Item 23a) (Type, Print) 8118

DHMH 17 Rev 7/2009

State Registrar Registra

's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death December 26, 2010 Physician/ 21:56 Loretta Ann Nauman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carrol1 If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Hours Min. 04/21/1939 71 213-36-4313 Director MD Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. 1 🗌 Yes 2 🔀 No Woodbine Carroll 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1289 Hoods Mill Rd. 21797 USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Houswife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Calvin Clabaugh Margaret G. Jager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or any Wilson F. Nauman(Husband) 1289 Hoods Mill Rd. Woodbine, Md. 21797. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lake View 12/30/2010 Sykesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-t Physician/Medical Box 68760 attending pl 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Jas performed' death? Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pendina within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie th (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

10-10036
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

naries Leonar		le, II State of Maryland . 1-For State Registrar	Department of Certificate of			eg. No. O O I	0 1 1 1
Physici Medical Exam	an/	Decedent's Name (First, Middle,Last)     CHARLES LEONARD NA	LE II		2. Date of Deal		3) Time of Death 2149 hrs
$\bigcirc$		4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center		4b. City, Town, or Location Glen Burnie		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)		1.00	th(MM/DD/YYYY) 9. Birt	n
Director		213–33–2490 1 M 2 F Usual Residence of Decedent	22 <sub>YI</sub>		August	17, 1988 Con	untryMaryland
d now any		10a. State 10b. County Maryland Anne Arundel	10c. City, Town or Loca	ation Pasadena			10d. Inside City Limits  1 Yes 2 No
death with the Maryland or items 23a or 28a-f show must be ootified at once.	Director	10e. Street and Number	<u> </u>	10f. Zip Code 21122	1	0g. Citizen of What Cour	
with the as 23 a o		4011 Belle of Georgia Avenue  11. Marijal Status 12. Was Decedent		/as Decedent of Hispanic Or		- 14. Race - Ameri	can Indian, Black,
ter death	Funera	1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	No If	Yes, specify Cuban, Mexical Yes 2 No specify		White, etc. White, etc. Specify:	ite
hours af hours af hours af Examina	ted by	Lor Dates: 15. Decedent's Education (Specify only highest grade com	during	ent's Usual Occupation (Give	kind of work done	16b. Kind of Business/I	ndustry
5-0036 led within 72 hours after tygient other than "natural", the Medical Examiner	Completed	12 0	· .	andscaper		Lawn Servio	ce
21215-00 ould be filed with 1 Mental Hygiene 1 marked other it	Be Co	17. Father's Name (First, Middle, Last)  Charles N. Nale			er's Name (First, Middle, I Nanette F. I		
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygies and anti- filence 27 is marked other than "natural", or items 23s or 28s-f sho or other traumatic evect, the Medical Examiner, must be contified at once	2	19a. Informant's Name/Relationship (Type, Print) Charles N. Nale (Father)	1	ng Address (Street and Nu Duvall Highway,			, Zip Code)
re, l s 1 and f Healt If item		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from Sta	20b. Place of Dispo	osition (Name of cemetery, other place)	Date	20c. Location - City or	
Baltimore, permit. Pages I at Department of He Important: If ite injury or other it		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Atlantic C	Name and Address of Facili	12-29-10	Glen Burnie,	
ம் ஐஃ்.∄்.≘ Physician	Н	23a. Part I. Enter the disse, or complications that caused	32	104 Mountain Road	l, Pasadena, Ma	ryland 21122	Approximate Interval
/Medical xaminer	٠.	100		Intoxication			Between Onset and Death
		Sequentially list conditions, b.					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last					
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'60, ate be ey physiciar he burial	Medical	IF FEMALE: 23c. If yes, outcor		per me g912	2-9-11 vt	23d. Date of delivery	,
Box 6876: death certificate: the attending physic for use as the	ician/N	23b. Was decedent pregnant in the past 12 months?	time of death	etal death 3 Ectop	ic pregnancy		Day Year
O. Bo.  It the deat  by the att	Physi	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death	n but not resulting in the	underlying cause given in P	Part I. 23e. Did to	obacco use contribute to	the cause of death?
ls, P.O. quires that then signed by	ted by				1 Yes	s 2 No 3 Prob	
of Vital Records, P.O. Box 68760, ig Physician: The law requires that the death certificate be executed fler this certificate has been signed by the attending physician and neral director, page 2 should be detached for use as the burial - transi	Completed				autop	psy prior to commed? death?	topsy findings available completion of cause of second No.
ital Recient: The scertificate rector, page	BeC	25. Was case referred to medical examiner? Hospital: 1 Inpatie			(Check only one)		
	n: To	1 V Yes 2 No  27. Manner of Death  28a. Date of Inju (Month. Day.Y	ent 2 ER/Outpatien	f Injury 28c. Injury at Wor	1	Residence 6 Other	:
Sion Attenc r death ector: by the	ertification:	Natural 5 Pending 1 Pendin	7-10 fd 9:0	5pm 1 Yes 2 x	unkno		ral Route Number City
Division the Hospital or At hin 24 hours after dute Funceral Direct napeted the Funceral Direct pletely filled in by	Certif	3 Suicide 6 X Could not be 4 Homicide (Specify)  29a Certifier 1 Certifying Physician: To the best of m	residence		or Town, S	State) 4011 Bel Pasadena, M	ral Route Number, City 1 Of Georgia d. 21122
To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier 1 Check only one) 2 ✓ Medical Examiner: On the best of m and manner stated.					
	ž	29b. Signature and title of certifier	1	29c. License number	r	29d. Date signed (Mo. December 28, 20	
X		3 Name and a Tress of person who completed cause of d			MD 04004	1	
		Zabiullah Ali, M.D. Assistant Medical Ex 31. Date filed (Month, Day, Year) 32. Registra		nn Street, Baltimore,	MD 21201		
Regis	trar	DEC 292010   Beach	ma B. B	ares			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of	Maryland	-	artment of I rtificate of I					2010	1041
			Registrar  1. Decedent's Name (First, Middle, La	ast)			tillcate of t	Jeaun		2. Date of Dea	Reg. No.		3. Time of Death
	Physicia		Jacqueline	Ruth	Newma	an				Decemb	er 2	L, 2010	
	Medic Examin	_	4a. Facility Name (if not institution, gir				4b. City, Town, o	r Location	of Death			County of Death	
and the	LAGITITI	JI	Stella Maris				Timon	ium			E	Balt <u>imo</u>	re
	Funeral		5. Social Security Number 6.	Sex 7. 1 □ M 2 😿 F	Age (In yrs. la		If Under 1 Year Months Days	If Unde	er 24 Hrs. Min.	8. Date of Birt	h /, Year)	Cou	nplace (State or Foreign
	Director	ļ	218-26-9912	TLIM Z KIF	79	Yrs.				(Month, Day 1)7/24/	1931	Ma	rÿland
	nd how	. I	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits
	laryla 3a-f s iffied	ect	MD		Ba	ltimo	ce						1 🗌 Yes 2 🔀 No
	or 2	₫	10e. Street and Number				10f. Zip Code					en of What Co	untry?
	s 23a ust b	Funeral Director	611 Light Street	t			21211				U.S.		1
Ē	death item ner m		11. Marital Status	12. Was Decede Armed Force	es?	. 13.	Was Decedent of H If Yes, specify Cub	lispanic C an, Mexic	origin? (Spec an, Puerto F	ify Yes or No- lican, etc.)	1	<ol> <li>Race - Amer Black, White</li> </ol>	
a 36	after ( I", or kamir	p	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	If Yes, Give			1 ☐ Yes 2 🕱 No	Specia	fy:		s	pecify: Wh:	ite
0 9:30 a 21215-0036	atura cal E	Completed	15. Decedent's	Year or Date Education	s.		dent's Usual Occu				16b. Kin	d of Business I	ndustry
9:	72 h an "n Medi	립	(Specify only highest Elementary/Seconday (0-12)	grade completed) College (1-4	or 5+)	(Give life. L	kind of work done OO NOT use retired,	during ma )	ost of workin	g '			
217	withir giene er th		12			Se	ecretary					Governm	ent
2010 land 2	filed tal Hy d oth event	To Be	17. Father's Name (First, Middle, Las							(First, Middle,			omn
yla	uld be Men narke natic	-	Frank Jose		uebel				ldred		laomi		emp
21, Maryl	2 sho th and 17 is r traun		19a. Informant's Name/Relationship			1	ing Address (Street 4 East Ri						Code
e, ER	and Healt tem 2		Kim Dell / Daug	ncer	20b. P	lace of Disp	osition (Name of			ate		cation - City or	Town, State
E E	age 1 ent of nt: If i y or c		1 ☐ Burial 2 ☐ Cremation 3 4 🕱 Donation 5 ☐ Other (Spe		late .		matory or other pla fts Regist		12/29,	/2010	Hane	over. M	laryland
DECEMBER Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Foheral Service	_	1.23%	-	2. Name and Addre	-					
ā ā	e a la para		1500	1)								anover,	MD 21076
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that car one cause on each	used the death line.	n. Do not en	ter the mode of dyi	ng, such a	as cardiac o	r respiratory ar	rest,		Approximate Interval Between
9	Ph_sician/	10	Immediate Cause (Final disease or condition	ESOPH	IAGEAL	CANCE	R						Onset and Death
-	Medical Examiner		resulting in death)	Due to (or	as a consequ	ence of):							
		r e	Sequentially list conditions,	b. Due to (or	as a consequ	ience of:		_					
	ed	Examiner	if any, leading to immediate Cause (Disease or iinjury	540.0 (5.	40 4 0011004							- 1	
	n and al-tra	Exa	that initiated events resulting in death) Last	C. Due to (or	as a consequ	ience of):							
09	ate be executed physician and the burial-transit	dical	•	d									
6876	tificate ng phi as th	Med	IF FEMALE:										
9 X	requires that the death certifica been signed by the attending pl should be detached for use as t	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 <b>X</b> No			I death 3	☐ Ectopic pregnar	псу			2	23d. Date of de Month	livery Day Year
NEWMAN P.O. Box	the a	ysic	1 Yes 2 <b>X</b> No 9 Unknown	9 Unkno		Jean 5							
NEWMAN, P.O. Bo	that the	y PF	Part II. Other significant conditions	contributing to dea	ath but not res	ulting in the	underlying cause g	given in Pa	art i.	23e. Did t	obacco us	se contribute to	the cause of death?
E N	uires in sigr	ed b								1 🗆	Yes 2	No 3 □ P	robably 4 🗆 Unknown
JACQUELINE 1 Vital Records,	w req	plet								24a. Was auto	nsv	prior to	topsy findings available completion of cause of
Rec	The la ate ha	lo mo								perfo	ormed? 2 <b>X</b> No	death?	s 2 No
E CO	cian; ertific ector,	Be (	25. Was case referred to medical examiner?	Hospital:					eath (Check				7007777
₽ ≥	Physic this c al dire	မ	1 Yes 2 No 27. Manner of Death	1 🗆 Ir		ER/Outpati 28b. Time	ent 3 LIDOA L	4 📖		me 5 Resi 28d. Describe			hify) HOSPICE
n O	ding I h. After funer	sate	1 X Natural 5 🗆 Pending	(Month	, Day, Year)	injury	wo	rk? ☐ Yes 2		EOG. Describe	now injury	Occurred	
sio	Attendary deat	Certificate:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place o	of Injury - At ho	me, farm, s	treet, factory, office	)				Number or Ru	ral Route Number,
Division of	al or / s after il Dire		4 - Hornicide determin	building	g, etc. (Specif)	"				City or To	wn, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Objects O Modical Eve	hysician: To the beaminer: On the basis	of evamination	n and/or inv	estigation in my onli	nion, death	a occurred at	the time, date	and place.	and due to the	cause(s) and manner stated.
	the L	Σ	only one) 3 X Certifying N 29b. Signature and title of certifier	lurse Practioner: To	the best of m	y knowledge	, death occurred at	the time, o	date and plac	e, and due to the	ne cause(s	and manner as e signed (Mont	stated.
	5 iv 6		11.NI	20 Most	0		21	197	92		17	2/21/2	010
			30. Name and address of person wi	no completed cause	of death (Iten	n 23a) (Type	, Print)	1.1.				1-1-	<u> </u>
			JACKIE JONES, 31. Date filed (Month, Day, Year)		0 DULA gistrar's Signa		ALLEY RD.	TI	MONTU	4, MD 2	1093		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27, 2010 Physician/ DECEMBER 6:29 P PATRICIA ANN OZAZEWSKI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD <u>UPPER CHESAPEAKE MEDICAL CENTER</u> BEL AIR 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthdav) **Funeral** 1 🗆 M 2 🔀 Days Mar. 3, 1944 Hours North Carolina 66 212-42-9072 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Abingdon 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21009 Completed by Funeral 1003 Vernon Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Elsie Mae Hatley James Bingle Motley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1003 Vernon Ct., Abingdon, Maryland 21009 Department of Health a Important: If item 27 is any injury or other tra once. Norman J. Ozazewski / Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 12-31-10 Gardens of Faith 4 Donation 5 Other (Specify) Signatu Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acerba Physician: MCCCC 6864 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of) burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last nding physician use as the buria 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day for Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s has performed? Yes 2 No 1 🗌 Yes 2 🗌 No certificate **Division of Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of sertifie 0057223 12010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Drive Bel Air MD 21014 Fermin Barrueto MD 32. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year)
DEC 2 9 2010

829

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 7:30 AM Decembe 2010 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign curity Number **Funeral** 1 □ M 2 🗹 Months Hours Min MO **Director** Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No Was Decedent Ever in U.S. 11. Marital Status 12 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify Specify: 3 
Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mo 21234 20a. Method of Disposition 20c. Location - City of Town, State 20b. Place of Disposition (Name of Date cemetary, crematory or other place, 1 

✓ Burial 2 

Cremation 3 

Removal from State MU 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Ons t and Death Immediate Cause (Final Physician Demento disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No npleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 MResidence 6 Other (Specify) 2 X No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) **⋈**Natural 5 Pending 1 Yes 2 No Accident A Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signature and tle of certific 29d. Date signed (Month, Day, Year) Recember 27 2010 m MD

State Registrar

5V

Name and address of person who completed cause of death (Item 23a) (Type, Print)

hilly F. MAC. MD.

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 41044 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Teresa В. Paonessa Dec. 2010 12:55 p<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death South River Health & Rehab Edgewater Anne Arundel 9. Birthplace (State or Foreign Country) New York Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 1 🗆 M 2 💢 F Months **Director** 090-16-4680 105 1905 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 154 Cranes Crook Lane 21401 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H Carmen Narcisse Annuniziat Muchacharo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health ar
Important: If item 27 is
any injury or other trau Irene Paonessa / Daughter 154 Cranes Crook Ln., Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1  $\square$  Burial 2 X Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) Metro Crematory Inc 12/29/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of Facility Cremation Society of Maryland Kittes 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Severe disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to impreciate Examine Directo (syries e consuminos of) cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: es, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 👿 No Month Pregnant at time of death 5 Other (specify) Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Cancer. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of De Jack (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 👿 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) hysician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 MAHBOOR YED Mapolis 401 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month 12 **Physician** PHILLIPS LORES 12:45 AM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE (SARDENS PIKESVILLE OURTLAND If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ W 217-40-3763 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ∏Yes 2 □ No traumatic event, the Medical Examiner must be notified Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 100 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Fiber Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event, tt once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21207 tarb Vnn Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 5 Other (Specify) 30/2010 4 □ Donation 21. Signature / Fri eral Service Linesee MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PALSY Immediate Cause (Final disease or condition resulting in death) SUPRANYCLEAR PaogressIVE Physician Zyears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) O 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð DEMENTER 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed HYPERTENSION 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? res 2 A No death? 1 ☐ Yes Vital 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 X Natural Injury 5 Pending investigation 1 □ Yes 2 □ No hours after death. 2 Accident Funeral Director: stely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6095 MARSHALEE DR, ElKRIDGE MI) ANAPOISKY, CRNP 32. Registrar sprignatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 24a, 26 pr verb., g910,12/29/2010dhb Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 1139 AM PEARMON TERUME Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAUT MONE CITY MANYLAND BALTMURE INIVERSITY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Month, Day, Year 217-52-1551 Maryland 42 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar miss has matter and 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8121 A. Elizabeth Rd. 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 KNo Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) A.A. Community Col Stationary Engineer vear Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ida Mae Smith William Pearmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. Elizabeth Rd., Pasadena, MD, 21122 8121 Sylvia Pearmon 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 DeBurial 2 Cremation 3 Removal from State 12/30/10 Baltimore, MD Cedar Hill Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD PA 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final CANDIAN ₽nysician/ DYSRYHTHMIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s death? certificate lirector, page Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 3 □ DOA 1 Inpatient 2 I 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Time of Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Cortiving thysician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Me loc Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Out thying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tit ABRAHAM 1316081557 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. GREENE MICHAGL ABILAHAM BROMORE MD 31. Date filed (Month Registrar's Signatur State casur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Alpha Lee Peery December 1:55 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Catonsville Catonsville Commons 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Virginia 7. Age (In vrs. last birthday) Funeral Days Hours 08-13-1912 1 M 2X F 214-24-2258 98 Director Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 U.S.A. l6 Fusting Avenue death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien. Office Manager Baltimore SPCA injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alpha Walker Rena Ashburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2520 Kenningston Gardens #406; Ellicott City,MD21043 Shirley Alonso, Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12-21-2010 Atlantic Crematory Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke Sign ture of Funeral Service Licenses Funeral Home of Catonsville, Inc 1630 Edmondson Avenue; Catonsvil 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final estivo Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 080 Man Toward yelows Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine and transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): anding physician a use as the burlal-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 bours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Chronic 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 8Reme performed? Yes 2 X N Chronic Kigney 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 XNursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident iniury 5 Pendina work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) December 20, 2010 1275 41 acetra Loya MD

State Registrar Forms

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Boltiman,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1/1)

2010

4367 Hollins

Registrar's Signature

RAJA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December 25 2010 Bertie E. **Poffel** 6:07pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Gilchrist Center Towson Baltimore Funeral Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Months Days Min. Hours July 16 1924 Director Flovd Co. 231 24 6631 86 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore County 1 Yes 2 X No. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5118 Kenwood Avenue 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Black White etc. ğ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2xx No Specify. 3 Divorced 4 Divorced Specify: Completed White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) N/A Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ C. Kinzer Quesenberry Menta Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Howard J. Poffel (Husband) 5118 Kenwood Avenue Baltimore, Maryland 21206 injury or other item 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Gardens of Faith Cem. December 29 2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 'n Lassahn Funeral Home 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. It most enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Dementa Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin sician and burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 1 Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed this certificate Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOS ( 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Division work? To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OV ANCES TOW SON M M 701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day 27 2010 Month 2:05 PM Physician/ Jecember Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Arundo anne. GEN BUTAL Baltimore Was hington Center Madea If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Day Yes Maryland Days Min. (Month, D. Jan 1X M 2 - F 44 1946 217-72-5065 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland notified at Director 1 Yes 2 No Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ıral", or items 23a o Examiner must be Funeral United States 21061 207 A Street S.W. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: White "natural", 3 Nidowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hou. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Merical once." 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Auto Body Mechanic 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nina Louise Young Thomas Lee Pressley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 A Street S. W. Glen Burnie, MD 21061 Pressley /Wife Teresa Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec 29 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2010 Chesapeake Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Narce and detection Family Funeral Alternatives M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician days disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner UMO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for rise as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month 4 Pregnant a Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hepatit 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? delerium tremens 24a. Was an autopsy performed 2 NO throm bo cytopenia Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 2 No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1. Natural work? 5 Pending 1 🗌 Yes 2 🛄 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 006815 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

DRIVE

HOSPITAL

32. Registrar's Signature

NOVACIO

31. Date filed (Month, Day, Year)

DEC 29 2010

BLERNIE, MD 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:64 PM Ann Pridgen Dacemi 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Hours Min. (Month, Day, Year) n. 12, 1941 North Carolina Director 242-68-5158 69 Jan. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r Funeral 8109 Alcoa Drive U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces Black White etc. Completed by 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Leroy Pridgen Bernice Foy permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Pridgen (Daughter) 8109 Alcoa Dr., Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Contains 5 ☐ Other (Specify) Pollock Cemetery 12/30/10 Wilmington, NC 21. Sign Ture of Juneral Service Licent John H. Shaw's & Sons Funeral Home 520 Redcross St., Wilmington, NC 28401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CARDIOPULMONARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypoxemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Mo tastatue Physician/Medical Carcinoma 42 0. LS Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death 4 ☐ Pregnant
9 ☐ Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Breust Wound 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 Impaired this certificate 2X No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Investigation Accident within 24 hours after death

To the Funeral Director: / 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my or faller, death of the cause of examination and/or investigation in my or faller, death of the cause of the c Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d, Date signed (Month, Day, Year) Muhael-D52865 120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis Rd Svite 200, Glem Dole MO 32. Regist State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ December 24° 20°f8 рм 1:25 Mary Ellen Robinson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel <u>Glen Burnie Health and Rehabilitation</u> Center Glen Burnie 8. Date of Birth If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗹 F A Qust 12, 1931 Mary land 79 Director 001-22-0702 Usual Residence of Decedent or 28a-f show be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 No Glen Burnie Anne Arundel MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 21060 USA 105 Sunset Drive 12. Was Decedent Eyer in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: 3 W Widowed 4 Divorced Black Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Worker State of Maryland 11th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leroy Davis Irene Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn I. Jackson - Daughter 105 Sunset Drive Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/30/2010 Lansdowne, Maryland Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Mt. Signature of Funeral Service Likensee 22. Name and Address of Facility Chalmen Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 in 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No the detached 9 Unknown P.O. ģ signed k Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 No prior to completion of cause of death? has this certificate 1 Yes 2 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural Accident (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of co 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CrawHighway SW GlinBarne MD 21061 208 31. Date flied (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene') Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day John Edwin Rosenberger Del 2016 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death St. Elizabeth's Nursing & Rehab. Cnt Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05–24–1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days 133-14-2562 NY 85 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1947 Bell Avenue 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Representative Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Edwin Rosenberger Alberta Glenroy Wheeler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori E. Manning - Daughter 505 Oak Grove Rd., Linthicum, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 No Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Meadowridge Mem PK. 12-27-2010 | Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signatur MMP., Inc., 7250 Wash Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MIN YER disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

items 23a or 28a-f show must be notified at

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Health and Mental Hygi em 27 Is marked other

permit. Pages 1
Department of P
Important: If ite
any Injury or ot

item 27 other tra

Director

Funeral

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Completed

Be

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with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examine Be Completed by Physician/Medical 2 Medical Certification: within 24 hours after common to the Funeral Director: Afterward of the funeral by the funeral by

To the Hospital or Attending Physician; The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)
an II. Other significant conditions	s contributing to death but not resulting in t	the underlying cause given in Pa
an II. Other significant conditions	s contributing to death but not resulting in t	the underlying cause given in Pa
Part II. Other significant conditions	s contributing to death but not resulting in t	the underlying cause given in F
25. Was case referred to medical examiner?	Hospital:	the underlying cause given in

			1 Yes 2. No 1 Yes 2. No							
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 No Hospital	tal: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ D	ome 5 ☐ Residence 6 ☐ Other (Specify)								
1 Natural 5 ☐ Pending 2 ☐ Accident investigation	Ba. Date of Injury (Month, Day Year)  28b. Time of Injury  M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not be determined 28e.	<ul> <li>Place of injury - At home, farm, street, factor building, etc. (Specify)</li> </ul>	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							

29a. Certifier (Check only one)	cian: To the best of my knowledger: On the basis of examination a and manner stated.			

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

252746 Dec., 22, 2010 folfin MD 2/22P

State Registrar

31. Date filed (Month, Day, DEC 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Howard Wilson Ridgley, Sr. DEC 7010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ACNES 1435P1 TAZ BALTMORE Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 11-16-1922 Country) **Director** 213-28-6244 Yrs 88 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County by Funeral Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 To No Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Charles Road 21090 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 K KNo If Yes, Give Year or Dates 1 ☐ Yes 2xxNo Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Steel Worker Aluminum Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Herbert F. Ridgley Mary Theresa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty A. McClernan - daughter P.O.Box 192, Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park 12-30-2010 Elkridge, Maryland 21. Signature of Funeral Service I 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph\_sician/ Onset and Death CURA disease or condition CFFUSIONS WEEKS Medical resulting in death) Due to (or as a consequence of) Examiner SEPSIS Z weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the burial-transi signed by the attending physician and abe detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No ည Other: 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury within 24 hours after death

To the Funeral Director: /
completed filled in by the f 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 00025844 050. 22,2010 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5411 DLD FREDCEICK 4. COMMERTORD, MO BALDMORE

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (MDECa), 2°9 2010

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. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Month VIRGINIA AILEEN MULLENDORE RIDGELY 2010 11:30 PM December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE Baltimore County Timonium Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days June 6 Months Hours 1 □ M 2 🔯 F 219-10-8618 85 Maryland Yrs Director 1925 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Baltimore County Lutherville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a USA 215 Margate Road 21093 items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ō 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify "natural", White Specify: 3 X Widowed 4 □ Divorced Completed other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunications <u>Clerk Supervisor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mullendore <u>Virginia</u> Starr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 William J. Ridgely, Jr. Page 1 and 2 215 Margate Road, Lutherville, Maryland 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date 1 

 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) 5 injury Dul. Valley Mem. Grdns 12/31/2010 Timonium, Maryland 21. Signatur France Lawson

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, any 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown be detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à or Attending Physician: The law requires Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed completed filled in by the funeral director, page 2 should has beer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No RIDGELY 24a. Was an autopsy certificate Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After 1 Natural 5 Pending injury work' 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F 3 🖟 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) News CRNF R 043580 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS, CRNP 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State Registrar 29

DHMH 17 Rev 7/2009

11:30

2010

DECEMBER

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. [1] State of Maryland / Department of Health and Mental Hygiene

		- For State	Cei	tificate of	Death		Re	g. No.	
Physician	1/	Decedent's Name (First, Middle,Last)					Date of Death     Month		3. Time of Death
Medical Examin		Mark Rose	Jr.		Cit. To	-1	Month December		2058 hrs
,		4a. Facility Name (if not institution, give street 1911 Casadel Ave	et and number)	4	o. City, Town, o Baltimore	r Location of Deatl	ו	4c. County of Dea	n/A
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Yes	ar If Under 24Hrs	s. 8. Date of Birth	(MM/DD/YYYY) 9. B	
Director	- 1	218-19-9274 <sub>1XM</sub>		22 Yrs.	Months Day			Fore	
	Ŀ	Usual Residence of Decedent							
w any		10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits
f sho	គ្ន	Maryland N/A				ltimore			1 X Yes 2 No
Mary Mary	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
th the notifi		1911 Casadel Avenu	e Was Decedent Ever in U.	0 [40.145		21230		USA	rican Indian, Black,
Baltimore, MD 21215-0036  Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Maral Hygiene. Important: If item 73 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	₩ I	1 Never Married 2 Married	Armed Forces?			spanic Origin? ( S n, Mexican, Puerto		White, etc.	rican indian, black,
fer de		3 Widowed 4 Divorced If Yes	Yes 2 No Giva Year	1 🗍 ,	Yes 2 X No	specify:		Specify: Wh	ite
ours a	<u>6</u>	15. Decedent's Education (Specify only hig	hest grade completed)			ation (Give kind of e. DO NOT use ret		16b. Kind of Business	/industry
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003 withir jene. Medi	Ē	11		(	Contract	18.Mother's Name	(First Balidalla Ba		ruction
filed Hyger of the	2 8 8	17. Father's Name (First, Middle, Last)  Mark W. Rose	C x			Debora			
212 uld be Menta mark		Mark W. Rose  19a. Informant's Name/Relationship (Type, F	Sr.	19b. Mailing	Address (Stre			nder ber, City or Town, Stat	e, Zip Code)
AD 2 sho h and 27 is		Mark W. Rose, Sr.	(father)	1911 (	Casadel	Avenue,	Baltimor	e, MD 212	30
e, Land Healt Fitem		20a. Method of Disposition		Place of Disposit	ion (Name of ce	emetery,	Date	20c. Location - City of	
TOF Pages ent of nt: If	- 1	1 Burial 2 Cremation 3 Re 4 Donation 5 Other Specify:	anovar nom state	etro Cre	,	Inc. De	c. 28 2010	Baltimore	. Marvland
altin mit. I partm. ports	ŀ	21. Signature of Funeral Service Licensee			me and Addres				Home, P.A.
		Ju 2 87						dena, MD	
Physician	:	23a. Part I. Enter the disease, or complication failure. List only one cause on each I was	э.				or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
examiner		Immediate Cause (Final Isease a. Or condition resulting in death)	Narcotic		Intox	ication			Death
	-	h	o (or as a consequence of	r):					
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<u>,,,</u>	E۱	cause. Enter Underlying Cause (Disease or iniury that initiated	) (or as a consequence of	5					
asi e d		events resulting in death) Last Due to d.	(0, 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
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760, cate be exe physician a			. If yes, outcome of pregr	nancy				23d. Date of delive	ry
Box 687 e death certific the attending p	Pnysician/	3b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of de	ath -	death 3	Ectopic pregna	ancy	Month	Day Year
30X Jeath e atter	S	1 Yes 2 No 9 Unknown 9	Unknown	atri 5 Othe	er (Specify)			1	,
that the detached		Part ii. Other significant conditions contr	ibuting to death but not re	esulting in the un	derlying cause	given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
res tha signed be det	<u>0</u>		_				1 Yes	2 <b>✓</b> No 3 Pro	bably 4 Unknown
ords, w require to be seen a should	Completed						24a. Was ai autops		utopsy findings available completion of cause of
Reco	Ë						perform		es 2 No
tal Rectant The certificate ector, page		25. Was case referred to medical		<del></del>	26.Place	e of Death (Check	only one)		
Vital   hysician: hysician: this certifi	0	examiner?  1 Yes 2 No	al: 1 npatient 2	ER/Outpatient	3 DOA	Other Nursir	ng Home 5 🗌 R	tesidence 6 🗸 Othe	er: Scene
ing Pl			Ba. Date of Injury (Month, Day, Year)	28b. Time of Inj		ıry at Work?	28d. Describe ho	ow injury occurred	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the start death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Certification:	2 Accident Investigation		fd 8:45 <sub>1</sub>	ш	Yes 2 🔀 No	unknow		
Jor A after after din br		Suicide Could not be	Re. Place of Injury - At horse	ome, farm, street	factory, office l	building, etc.	28f. Location (St	reet and Number or R	ural Route Number, City <b>Baltimore</b> , M
Division ospital or Attenctions after death nuneral Director: ly filled in by the		4 Homicide	apeary)	o dooth see	ad at the time.	ate and place.			
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	<u> </u>	one) 2 ✓ Medical Examiner:On the							
To To com	Mec.	and r 29b. Signature and title of certifier	nanner stated.		29c. Licens	se number		29d. Date signed (M	onth, Day, Year)
		Man - March	113		O.C.	M.E.		December 25, 2	010
4	-	30. Name and address of person who comple	eted cause of death (Item	23a)			I		
$\psi$			int Medical Examin		nn Street, B	altimore, MD	21201		
Stat	_	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re					
Registra	-12		thank a FV AND	CONTRACTOR OF THE PARTY OF THE					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7520M Bessie Caroline Rupp 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death baltimore manhlin rosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 🛛 F Months Hours Min. Month, Day, Yea 08/05/192 Director Yrs. 216-16-8025 Marvland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2🌠 No MD Baltimore White Marsh ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 5909 Loreley Beach Road 21162 U.S.A. hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Secretary John L. Lynch Co Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be nent of Health and Ment Charles E. Taylor Roberta Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Remmey 4 Randell Avenue - Perry Hall, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 12/30/2010 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. Signature of Funeral Service Licensee 6 assall Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ neumonia disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner Sequentially list conditions. ner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) 216168025 Pt Dir Ind: Y IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☑ No Month Pregnant at time of death Dav Year 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown MR# 08/05/1922 88 F M ALABRASH, MOHAMAD PA / IMC Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 

Yes 2 □ No 3 □ Probably 4 □ Unknown 3027244056 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fune the Hospital or Attending ✓ Natural injury 5 Pending Division work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29c. License number David 30. Name and address of person who completed cause of death (Item Se) (Type, 900 Coltimore, MD 21237 MD 31. Date filed (Mor DEC 29 Registrar

Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)		ertificate o	. 20001	-	2. Date of Dea			3. Time of Death
Exami		Keith Lee 1	20binsor	<b>1</b>			Month December	Day r <b>25</b> , 20	Year 10	0230 hrs
		4a. Fecility Name (if not institution, give str 4100 Ridgewood Avenue	eet end number)		4b. City, Town, or L Baltimore	ocation of Dea	th	4c. C	ounty of Death	4
ıneral		5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24H	_		YYYY) 9. Bir	thplace (State or
ctor		Usual Residence of Decedent	2_F	23 Yrs		Hours M	07/09	198		untry) MD
v any		10a. State 10b. County	10c. Ci	ity, Town or Local						10d. Inside City Lin
ns 23s or 20st-1 snow be notified at once.	ţ	10e. Street and Number		Baut	MDPe 10f. Zip Code		11	Og Citizen	of What Cou	1 Yes 2
tiffed a	Director	4016 Grantley 1	20ad		212	45		- g. <u>-</u>	USA	,,
27.7	Funeral	11. Marital Status 12 1 Never Married 2 Married	. Was Decedent Ever in Armed Forces?	If Y	as Decedent of Hisp es, specify Cuban,			- 14.	Race - Ameri White, etc.	ican Indian, Black,
ner mu	by Fu	3 Widowed 4 Divorced If Ye	Yes 2 X No es, Give Yeer Dates:		Yes 2 No	specify:		Sp	ecify: Bla	ack.
- Name	ted b	15. Decedent's Education (Specify only hi			nt's Usual Occupations of working life.				of Business/I	
the Medical Examiner	Completed	12th grade	N/A		Stude	ent			Stud.	ent
1, the A	Be Co	17. Father's Name (First, Middle, Last)	nson		11	3.Mother's Nam	ne (First, Middle, M			NES
tic event, t	To B	19a. Informant's Name/Relationship (Type,	Prjnt )		g Address (Street	and Number or	Rural Route Num	ber, City o	r Town, State	
other traumatic		Darlene James 20a. Method of Disposition	/Mother		Grantle		d Balthr			2/2/5 Lown, State
[]		1 Burial 2 Cremation 3 F	Cellioval Holli State	aid Di	ition (Name of cem placemete (ge Conte	En Dil	7/2011	MOOG	liawii A	1D 11 D
injury or ot		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	01		lame and Address		mann C.	Gree	ne Flun	eral Sorvice
.≣ in	4	23a. Part I. Enter the disease, or complicati	ons that caused the dea	th. Do not enter t	128 Libe he mode of dying, s	V14 PO		260.00	or heart	Approximate Inte
al er		failure. List only one cause on each line Immediate Cause (Final disease a. Mul	<sup>ne.</sup> tiple Gunshot Wou	unds		0				Between Onset : Death
"			to (or as a consequence	of):						
	iner	cause. Enter Underlying Cause	to (or as a consequence	of):						
ransıt	Examiner	(Disease or injury that initiated events resulting in death) Last	to (or as a consequence	of):						
1	_ \	d. UNPENDED AM	MENDED						<del></del>	
1000		IF FEMALE: 23 23b. Was decedent pregnant in the	Bc. If yes, outcome of pre	_		1			ate of delivery	
	ician	past 12 months?	Live birth Pregnant at time of	death -	tal death 3 _ her (Specify)	Ectopic pregr	nancy	Mo	nth D	Day Year
	Phys	Part II. Other significant conditions con	Unknown	t resulting in the I	inderlying cause div	en in Part I	23e Did to	hacco use	contribute to	the cause of death?
	à		aribating to dodin bat not	rosulting in the c	indenying cadso gri	CITITY CITE.			o 3 Prob	
anonia oc acaca	Completed				_		24a. Was a autop:	sy	prior to c	topsy findings avail- ompletion of cause
	E O						perfor 1 Yes		death? 1 ✔ Ye	s 2 No
director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	tal: 1 Inpatient 2	ER/Outpatient		ther Nurs		Residence	6 ✔ Other	: Scene
l	-	27. Manner of Death	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of In FOUND:			28d. Describe h Subject shot		occurred	
١	catic	2 Accident Investigation	Dec 25, 2010 28e. Place of Injury - At	0220 hrs		s 2 V No			Number or Ru	ral Route Number, (
tilled ill of	Certification:	3 Suicide 6 Could not be determined 4 ✔ Homicide	(Specify) Local Stre				or Town, St 4100 Ridgewo	ate)		
completely		29a. Certifier (Check only one) 2 Medical Examiner: On the control of the control		-						
	Medical		manner stated.		29c. License					nth, Day, Year)
		Mass C	717		O.C.M	.E.		Decem	ber 25, 20	010
	ı	30. Name and address of person who comp	•	,	Penn Street, E	Raltimore A	*D 21201			
		Russell Alexander MD. Ass	istant Medical Exa	miner iii	Lelli gueer L					

DHMH 17 Rev 1/2001 OCME 2006

10-09817		Please Type or Print in Black Indelible Ink. Ensure All Copie		gible.	4105
Richard Anthony R	1 F	- For State Certificate of Death	R	6g. No.	9103
Physician	-	1. Decedent's Name (First, Middle, Last)	Date of Dea     Month	Day Year	3. Time of Death 1125 hrs
Marine Examine		Richard A. Rottmund, Jr.  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		r 20, 2010 4c. County of Death	
	ı	4 Livia Court Apt. 3A Rosedale		Baltimore Cou	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	→	th(MM/DD/YYYY) 9. Bir Foreig 1953 Pen	
any		Usual Residence of Decedent  10a. State			10d. Inside City Limits
<b>*</b>	1	MD Baltimore Baltimore			1 Yes 2 No
Baltimore, MD 21215-0036  Permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  In marked other than "matural", or items 23a or 28a-f show injury or other traumatic event, the Medical Extensive must be notified at once.	3	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cour	ntry?
the M tiffed diffied Direct		4 Livia Court - Apt. 3A 21237		U.S.A.	
er death with it is or items 233	5	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.			can Indian, Black,
or ite		1 Yes 2 No	Ricari, Gic.		
ural",	\$-	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v	vork done	Specify: Whit	
5-0036 ed within 72 hour 1/9 giene. other than "natu the Medical Exem		Elementary/Secondary (0-12) College (1-4 or 5+)  during most of working life. DO NOT use reti			,
215-0036 se filed within 7 tral Hygiene. ked other than ent, the Medica		12 3 Restaurant Manager		Restauran	nt
filed w Hygid d other		17. Father's Name (First, Middle, Last)  18. Mother's Name	_	Maiden Surname)	
2121; could be fill d Mental Is s marked fic event,		Richard A. Rottmund, Sr. Jean Smo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F		ober City or Town State	Zip Code)
MD d 2 shot. Ith and l n 27 is rumatic	1	Helen Rottmund (sister) 18 Surrey Lane - Balt			21236
Ce, No. 1 and Health Fitem		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	
altimore, mit. Pages lar partment of Hee portant: L'iter iury or other tr	-	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Moreland Mem. Park Cent. 12	/28/2010	Baltimore,	Maryland
Calti	-	21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.	F. Lassa	ahn Funeral	Home, P.A.
	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o	- Kings	ville, Maryl	and 21087 Approximate Interval
Physician	1	failure. List only one cause on each line.	r respiratory arr	est, snock, or neart	Between Onset and  Death
£xaminer		Immediate Cause (Final disease or condition resulting in death)  Probable Seizure  Due to (or as a consequence of):			Beaut
		Sequentially list conditions,			
amine.		if any, leading to immediate Due to (or as a consequence of):			
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be existing sicting with a second		X UNPENDED AMENDED 23a,pt.II,27 per me g912 2-9-1	ll vt		_
). Box 68760, the death certificate be executed by the attending physician and ched for use as the bunal - transi Physician/Medical Ex	2	F FEMALE:  23c. If yes, outcome of pregnancy  1 Live birth  2 Fetal death  3 Ectopic pregnancy	ancy	23d. Date of delivery  Month	ay Year
th cert		past 12 months?  4 Pregnant at time of death 5 Other (Specify)			
. BC the dea		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did to	bacco use contribute to	he cause of death?
cords, P.O. law requires that the has been signed by 2 should be detach	2	Atrial Fibrillation on Counadin		s 2 No 3 Prob	
Records,  The law requirer ficate has been sig. page 2 should be		Herrican on Country	24a. Was		opsy findings available
COF e law r e has b e 2 sh				rmed? death?	ompletion of cause of
I. The uificate or, pag		25. Was case referred to medical 26. Place of Death (Check	1 Yes	2 No 1 Ye	s 2 No
n of Vital Rec ing Physician: The After this certificate funeral director, page	5	examiner?		Residence 6 🗸 Other	Scene
of Ving Physical distribution of the original		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d, Describe	now injury occurred	
ion frendi death. tor: / the fi		1 X Natural 5 Pending 1 Yes 2 No			
Division of Vital Records, P.O epial or Attending Physician: The law requires that the law after death after this certificate has been signed by filled in by the funeral director, page 2 should be detac Certification: To Be Completed by E		3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, S	Street and Number or Rui tate)	al Route Number, City
C File bound		4 Homicide  29a. Certifier 4 Continue Physician Table based on the based of the birth date and place and	due to the	o(c) and manner as at at	A
To the Ho within 24 To the Fu completely	3	(Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
P. S.		and manner stated.  295. Signature and title of certifier  29c. License number		29d. Date signed (Mon	th, Day, Year)

State Registrar

31. Date filed (Megth, Day Year)

Zabiullah Ali, M.D.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 32. Fegistrar's Signature

111 Penn Street, Baltimore, MD 21201 ORIGINAL

O.C.M.E.

OCME

December 21, 2010

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene 2 U State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Thomas Reilly December 27, 2010 4:25 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 1321 Locust Ave. Bel Air Harford 5. Social Security Number 0080 Age (In yrs. last birthday) 6. Sex 1 🖾 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours July Day Year) 1965 Martyland Director 215-72-0<del>800</del> Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits Director Harford 1 Yes 2XXNo Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1321 Locust Ave. 21014 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 XX Married ☐ Yes 2XIX No Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Specify 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Division Manager Flooring Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William M. Reilly, Sr. Shirley A. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa L. Reilly (spouse) 1321 Locust Ave. Bel Air, Maryland 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State **Baltimore** Date cemetery, crematory or other place) 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State 12/29/10 Bayview Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Rel Air min D. 610 W. MacPhail Rd. Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Fifteen months GLIOBLASTD MA MULTIFORME Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) ☐ Pregnant ☐ Unknown Pregnant at time of death Month Day Year ☐ Yes ∠ ∟ ☐ Unknown signed by the sid be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed 1 ☐ Yes 2 🗷 No Yes 2 🔀 : After this certificate funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) B B Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury □ Accident □ Suicid 1 Tes 2 No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 💌 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) d 355 22. décember 28,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUÉ BEL AIR MARYLAND 21014 NORTH 32. Registar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robin arch 11:53 Medical 2016 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mount airn Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 □X Months Days Min. Hours  $\frac{Month}{1}$  $\frac{Day}{2}$ 214-84-7737 48 Country) <sup>Ye</sup>17962 **Director** Jan MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location
Mt. Airy filed within 72 hours after death with the Maryland 10b. County Director 10d. Inside City Limits MD Carroll 1 Tes 2 No 10e. Street and Numbe 10f. Zip Code iral", or items 23a or Examiner must be i 10g. Citizen of What Country? Funeral USA 5129 Perry Road 21771 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 XMarried Black, White, etc. þ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 🗌 Widowed 4 🗌 Divorced Specify: White "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) administrative assistant city government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Sherwood Willard Klinke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $5129\ Perry\ Road$  , Mt. Airy , MD 21771Charles G. Robinson Jr. (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If if
any Injury or o 1 XBurial 2 Cremation 3 Removal from State Pine Grove Cemetery 12-31-10 Mt. Airy, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility  ${\sf Haight\ Funeral\ Home\ \&\ Chapel}$ Elian C MOO 164 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician. 6/4/06 40 12/74/ Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or linjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Day Year Yes 2 1 Mo 1 ☐ Yes ∠ ☐ 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed? 2 1 1 🗌 Yes 2 4 No after death.

Director: After this certific In by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 40 Other: ျဉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a completed filled Medical 1 🖵 👉 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier ತಿ 29d, Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) and address of person who completed cause Street

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department of Certificate of Registrar		al Hygiene Reg. No.	2010 41061
	Dhysisi	20	1. Decedent's Name (First, Middle, Last)		ate of Death onth Day	3. Time of Death
	Physicia /Medic		Marion Iona Richard		cember 22	2, 2010 5:30 PM
	Examin	er	,	or Location of Death		ounty of Death
angle of the same	c		Glen Meadows Retirement Community Glen As  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea			1timore
	Funeral Director		178-03-9952 1 M 2 N F 92 Yrs. Months Days		ate of Birth fo <i>nth, Day, Year)</i> ch 9, 191	9. Birthplace (State or Foreign Country)     Pennsylvania
	pur *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-f sho	ctor	Maryland Baltimore Glen Arm			1 □Yes 2 No
	th with the 23a or 28	Funeral Director	10e. Street and Number 11630 Glen Arm Road, Apt. G03		10g. Citize	en of What Country?
9800	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madfall Exerciting Frankland at		1 □ Never Married 2 Married 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No If Yes, The Year or Dates:			4. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 ho iene. • <b>than "natu</b>	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retir	upation e during most of working red)	9	d of Business/Industry
	filed wii Hygien other th		12 Office Worker	- - <del>1</del>		rance Company
and	should be filed and Mental Hygi s marked other sumatic event,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs		urname)
Ž	should be and Mental s marked o umatic ev	욘	W. Edward Kulp	Clara Mary   et and Number or Rural Rou		Taum State Zin Code)
Maryland	d 2 sl Ith an 17 is r traur		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Streen Linford Richard / Husband 11630 Glen Ar			
	s 1 and 2 r Health tem 27 i		20a. Method of Disposition 20b. Place of Disposition (Name of		<del></del>	ation - City or Town, State
m 0	Pa T:		M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ☐ High and Mem. Par	i	n Potts	town, PA
Baltimore,	permit. Pages 1 ar Department of Hee Important: If Item any Injury or othe once.		21. Signature of Funeral Service Licensee 22. Name and Add	ress of FacilityMcComa:	s Funeral	Home, P.A.
	402.00	-	23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of d		11/11/11/11/11	, Maryland 21009  Approximate
			shock, or heart failure. List only one cause on each line.		onatory arrost;	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	H .		5 days
7	Examiner					
	led sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury			22
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
68760,	ficate be execute I physician and s the burial-trans		d.			
.89	tificat ng phy as th	ledical				
O. Box	or Attending Physician: The law requires that the death certificate be executed after death. Carter this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specify)			3d. Date of delivery Month Day Year
of Vital Records, P.	uires that signed b Id be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of PARKINGON'S DISEASE ALZHEIMERS DEMENT	given in Part I.		e contribute to the cause of death?
000	w requir s been s should	lete	ALZHEIMERS DEMENT	7	24a. Was an	24b. Were autopsy findings available
- R	The law cate has page 2 t	Completed			autopsy performed? Yes 22No	prior to completion of cause of death? 1 □ Yes 2 □ No
ita	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Che		
<u></u>	Physic this ce al dire	To E	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	other: 4 Nursing Home	5 ☐ Residence 6	Other (Specify)
n o	<b>ding Ph</b> h. After th funeral	on:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. In Section 2		Describe how injury	occurred
Sio	ttend Jeath tor: /	icati	2 Accident investigation M 1 3 Suicide 6 Could not be determined	□Yes 2□No	ocation (Street and	Number of Rumi Poute Number
Division	I or Attendi after death. Director: A I in by the fu	Certification:	4 Homicide determined determined building, etc. (Specify)	201. [	City or Town, State)	Number or Rural Route Number,
)	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in m and manner stated.			
	o the	Mec		nse number	29d. Date	signed (Month, Day, Year)
	F > F 0			51228	12	124/2010
•	(ev		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  R ATTHEN TO A LAW WILLIAM CONTROL TO THE STILL INC.  (ReSSILL)	<i>J</i> /		
	Sta	te.	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registr		31. Date filed (Month, Day, Year)  DEC 2 9 2010  Server 32. Registrar's Signature			

DHMH 17 Rev 1/2001

		Please Type or Print in Bl State of Maryland  1 - State Registrar	/ Depa		lealth and I	Mental Hy		2010	41062
Physicia Medic		Decedent's Name (First, Middle, Last)     MARY ELIZABETH ROBINSON		-		2. Date of Dea Month DFCFMBF	ER 2	2, 2ďľo	3. Time of Death 9:00 A M
Examin Funeral		4a. Facility Name (if not institution, give street and number)  3301 Clayton Road  5. Social Security Number  6. Sex 1 M 2 T F R 2		4b. City, Town, or  Joppa  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	I I	County of Death Harford  9. Birth	place (State or Foreign
Director show ta p	tor	Usual Residence of Decedent	Yrs. Town or Loc		TIOUIS WIII.	May 2	2, 19		10d. Inside City Limits
ith the Mary 23a or 28a-f st be notifie	Funeral Director	Maryland Harford Jo  10e. Street and Number  3301 Clayton Road	oppa	10f. Zip Code 2108			10g. Citi	zen of What Cour	1 Ves 2 No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	l lf	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No- Pican, etc.)	,	14. Race - Americ Black, White, Specify: Bla	etc.
within 72 hour giene. er than "natu , the Medical	Completed	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	ent's Usual Occupa ind of work done d O NOT use retired) aker		king		nd of Business In	dustry
ould be filed d Mental Hy marked oth matic event	To Be	17. Father's Name (First, Middle, Last)  Raymond Austin Turner  19a. Informant's Name/Relationship (Type, Print)	401 14-77		Ruth V	ne (First, Middle, Yiola Ha	L1		2-4-1
1 and 2 sho of Health an item 27 is other trau		Brinton Robinson / Son  20a. Method of Disposition 20b. Plac	3305 ce of Dispos	g Address (Street a Clayton	Road, Jo		ryla:		
permit. Page Department of Important: If any injury or once.			macle M	e UMC Cen	n. 12-2 Merali Ho	27-10 me, P.A.		lston, M	
Physician/		23a. Part 1. Erker the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	o not ente	<u>317 Cokes</u>	bury Roa g, such as cardiac	d, Abing	gdon	, Maryla	nd 21009 Approximate Interval Between Onset and Death
Medical  Examiner  the purial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  Due to (or as a consequence)  Due to (or as a consequence)  C.  Due to (or as a consequence)	ice of):		`				
e death certific the attending r hed for use as	Completed by Physician/Medi	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	eath 3	Ectopic pregnanc Other (specify)	у		2	23d. Date of delive	ery Day Year
quires that then the signed by sould be detac	ted by Ph	Part II. Other significant conditions contributing to death but not resulti	ing in the ui	nderlying cause giv	en in Part I.				ne cause of death? bably 4 🗆 Unknown
sician: The law re certificate has be lirector, page 2 sh		25. Was case referred to medical		26 Dia	ace of Death (Chec		sy	24b. Were auto prior to co death? 1 \(\sum \) Yes	psy findings available mpletion of cause of
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Certificate: To Be	examiner?  1	NOutpatien  Bb. Time of injury	t 3 DOA Othe	r: 4 □ Nursing H at			Other (Specify occurred	)
pital or Attu ours after de eral Directo filled in by ti		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)  29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge.			data and place a	City or Tow	n, State)	Number or Rural	
To the Hos within 24 h To the Fun completed	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best of my known only one) 3 Certifying Nurse Practioner: To the best of my known only one of the best of the best of my known on the best of m	nd/or investi	igation, in my opinio	n, death occurred a time, date and pla	at the time, date ar ce, and due to the	nd place, cause(s)	and due to the car	use(s) and manner stated ated.
41		30. Name and address of person who completed cause of death (Item 23 Charles Boise, MD 9103 Frankl	a) (Type, P	rint) uare Dr.	9910 Baltim	ore, MD		15-2	3-10
Stat Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature  DEC 2 9 2010  August A. Apar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 25<sup>ay</sup> George Bosley 2010 11:45 Am Royston Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Broadmead Cockeysville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F Months Hours Apy 11 21 Year 1917 214-38-3255 Marw Tand Director 93 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Iem 27 Is marked other than "natural", or items 23a or 28a-f shov or 28a-f shown notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Cockeysville 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or iner must be n Funeral 13801 York Road 21030 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Department of Health and Mental Hygiene.
Important; If item 27 Is marked other than "natural", or itel
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1 X Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Elementary School Principal Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ George Bosley Royston Katherine Eicholts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Carruthers Road Sewanee, Tennessee 37375 Pamela Macfie / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Memorial Gdm 12/29/2010 Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Samuelices 22. Name and Address of Facility ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician. Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any health gite in mediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
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3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) within To the 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

10-10016 Barbara Shook

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 41064 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.											
Physician Medical Examina	7		ecedent's Name (First, Middle,Last)							Date of Death Month Day Pear December 27, 2010  3. Time of Death 0200 hrs			
		Facility Name (if not institution, give street and number)     Sinai Hospital		umber)	4b. City, Town, or Location of Death Baltimore			ath	4	4c. County of Death N/A			
Funeral Director		5. Social Security Number	6. Sex 7. Age (In yrs. last birth		birthday) Yrs.	Months Days Hours Min.				1 Foreig		place (State or PA	
ow any	ľ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits  1 Yes 2 No		
th the Maryland 23a or 28a-f show	Ulrect	Maryland Baltimore Lu 10e. Street and Number  2128 Eastridge Road				therville   10f. Zip Code   21093				tizen of Wh	at Count		
or items	Laue	11. Marital Status  1 Never Married 2 Married 2 Armed Forces?  1 Yes 2 No  3 Widowed 4 X Divorced If Yes, Give Year				Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)      Yes 2 X No specify:				White, etc.			
36 n 72 hour nao "oatu lical Eran	Completed by	Tor Dates: Will Le									dustry		
21215-0036 and be filed within 77 Mental Hygiene. marked other than c eveot, the Medical		17. Father's Name (First, Middle Kenr	e, Last)	. Wil		e_FTaccit	3.Mother's Na	me (First, Mic	ldle, Maide	n Surname)		abley	
MD 21 ad 2 should ulth and Me m 27 is ma aumatic cv		Kenr 19a. Informant's Name/Relation Judy Wilson	ship (Type, Print) Sister		32797	Greens	and Number o	or Rural Route	o Number, o	elawar	re i	19966	
MOCE Pages I ent of H unt: If i		20a. Method of Disposition  1 Burial 2 Tormation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Note that the content of the plant					rp. 1	Date 2–28–10		Location -	•	aryland	
	1	21. Son tur Fun Service 23a. Part I. Enter the disease, o	tagan_	caused the death. D	10	me and Address of Sork	Road	Towso	n. Ma	rvlano	1 2	OME:, Inc. 1204 Approximate Interval	
Physician /Medical Examiner		failure. List only one cause Immediate Cause (Final diseas or condition resulting in death)	e on each line. <sub>e a.</sub> <mark>Intracrani</mark> a	al Hemorrhage a consequence of):	o not onto the	, mode of dying, of	99, 40 04, 514	o or roopirate	, , , , , , , , , , , , , , , , , , , ,	modi, of mod		Between Onset and Death	
ed	Iller	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		a consequence of):									
		events resulting in death) Last Due to (or as a consequence of):  d.											
760, reate be executed g physician and the burial - transit		UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery											
		23b. Was decedent pregnant in the past 12 months?  1							-	Month	Da	ay Year	
S, P.O.  Lires that the signed by the detached	<u> </u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						_ 1[	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ✔ No 3 ☐ Probably 4 ☐ Unknown				
Division of Vital Records, P.O tal or Atteodiog Physiciso: The law requires that te ra after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detachting the funeral director.	Сошріете								24a. Was an autopsy autopsy performed? 1			empletion of cause of	
Vital Rec		25. Was case referred to medic examiner?					of Death (Che	ck only one)					
Physic aldire	<u> </u>	1   Yes 2   No	Hospital: 1		R/Outpatient			sing Home			Other:		
sion of viteodiog Phodeath. ctor: After tly the funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury FOUND: Day, Year)  28b. Time of Injury FOUND: 128c. Injury at Work?  FOUND: 1000 hrs							28d. Describe how injury occurred Subject fell				
Divis	5	Suicide Could not be determined (Specify) Single Family Home						or To	28f. Location (Street and Number or Rural Route Number, City or Town, State) 2128 Eastridge Road, Lutherville Timonium, Md				
Division  To the Hospital or Atteot within 24 hours after death To the Fuoreral Director: completely filled in by the	adicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
· '		29b. Signature and title of certif	all the or certifier				29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) December 28, 2010			
0		30. Name and address of perso Zabiullah Ali, M.D.	Assistant Medi	cal Examiner	111 Penn	Street, Baltin	nore, MD	21201				The state of the s	
Stat Registra	te ar	31. Date file Month, 23,9°2	010 A 32 F	Registrar's Signature	park					,			

Division of Vital Records, P.O. Box 68760

SILVERTHRONE, LINDA

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) I handhary PAS 18006 December 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JYOTI CHAUDHARY Baltimore Hospital Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

子0201

24/2010

State of Maryland / Department of Health and Mental Hygiene [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 26. Spencer when Adams 2010 10:12 P M December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4h City Town or Location of Death 4c. County of Death Gaithersburg Montgomery 304 Kent Oaks Way Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month, Day, Year) 931 1 □ M 2 🕱 F Months Min Hours Louisiana **Director** 218-24-6440 79 Usual Residence of Decedent show 10a. State 10h. County 10d. Inside City Limits notified at 10c. City, Town or Location Director 28a-f 1 🔀 Yes 2 □ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be Funeral 23a United States 304 Kent Oaks Way 20878 items 2 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o Department of Health and Should be Department of Health and Menta Important. If item 27 is marked any injury or other traumation once. မ Scott Amanda C. Carrier Thomas Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9816 Carmelita Drive Potomac, Maryland 20854 Stephen Spencer/son altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Journey Crematory 12/31/2010 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Kyhomas uanita M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MASOPHER 105 years disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) -transit resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) 1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months?

1 Yes 2 No Year Month Day signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIMME Records, 1 Ves 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 1 Yes 2 No ☐ Yes 2 No Division of Vital 25. Was case referred to medical To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Sulcide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 044157 December 27,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 Locks Road, Rockville. wo. 1901 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12-27-2010 3:44P Jean Elizabeth Strickland Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Seasons Hospice Fallston If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Days 5-(Month, Pay Year) Director 219-32-3448 74 Maryland Usual Residence of Decedent 28a-f shov minoriam: It tiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City. Town or Location 10d. Inside City Limits **Funeral Directo** Md. 1 Yes X No Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21047 USA 1217 Peachtree Road permit, Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items DECEMBER 27, 2010 3:44 p.m. Baltimore, Maryland 21215-0036 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black, White, etc.
White Armed Forces?

1 Yes 2 V No ģ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Divorced 4 Divorced Specify: Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick J. Aull Helen Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 1209 Cheshire Lane BelAir, Md, 21014 Nancy J. Gede 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Highview 12-30-2010 Fallston, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Eugeral Septice (Consee 22. Name and Address of FacilitSchimunek Funeral Home 610 W. MacPhail Road BelAir, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a. BREAST CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injure that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be JEAN STRICKLAND Division of Vital Records, P.O. Box 68760 attending physial for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ cate has been signed by the atte page 2 should be detached for in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \bar{X} \) No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 T Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending after death. Accident Investigation 2 ☐ Accider 3 ☐ Suicide the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature an address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 600 Scheppske December 27,2010 Dona1d Wayne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Glen Burnie 408 Fernglen Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland Sex 1X M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Aug. 23, 1960 216-80-3501 50 Director Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD <u>Anne Arundel Co</u> Glen Burnie ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 408 Fernglen Avenue 21061 United States death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married ģ 1 Yes 2 No If Yes, Give X No Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: "natural" Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event to once. (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Deck & Fencing Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Roland Scheppske Ruth E. McAdams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kimberly O. Scheppske /Wif <u>408 Fernglen Avenue Glen Burnie, MD</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/30/2010 Atlantic Crematory Glen Burnie, Maryland 21. Signature of Funeral Se 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA Ave SW: Glen Burnie. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ VdIAZ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list monditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Records, P.O. Box 68760 the attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ ò in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year hed Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 🗆 No 3 📈 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 Yes 2 No Yes 2 No s after death.

al Director: After this certificated in by the funeral director, p Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 X Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier ROUT completed cause of death (Item 23a) (Type, Print) 21035 ones 695 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 28, 2010 6:20 A M MARY ANNE STEMPLE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Gilchrist Center @ GBMC Towson If Under 1 Year 8. Date of Birth
Feb. 4, 1927 Social Security Number if Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 Days West Virginia 83 Director 232-32-6845 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2x No Edgewood <u>Marvland</u> Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21040 USA 623 Hornbeam Road 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Madge Anne Thorpe Troy Wilbur Simons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 623 Hornbeam Road, Edgewood, Maryland 21040 Virgil Andrew Stemple / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gdn 12-31-10 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bel Air, Maryland 4 ☐ Donation 5 Ø Other (Specify) Entombment Signature of Funeral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 antivasce Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 wonths?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown No signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy perform 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 Tes 2 / No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mariner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ark

State Registrar 31. Date filed (Month, Day, Year)

29

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on who completed cay

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ZUIU State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Year 7:30 AM 24, Margaret Odessa Slater December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Baltimore Lutherville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 Det Months Director 73 Virginia 225-46-1362 Feb 04, Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 No Harford Edgewood 10e, Street and Numbe 10g. Citizen of What Country? 10f. Zip Code by Funeral 1922 Southridge Drive 21040 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ò Yes 2 No 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give "natural" 3 Divorced 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) within 72 Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Home Maker Be be filed 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) ပ John Evans Josie Ricketts and 2 should by Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Slater /Husband Jerome 1922 Southridge Drive Edgewood, MD 21040 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Dec 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2010 Signature of Funeral Service Licenses 22. Name and Address of Facility M0144 Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Jas autopsy death? certificate ☐ Yes the Hospital or Attending Physician; Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) ARGA 1 ☐ Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 27, 2010 SHUMAN 8:00 AM **JEROME** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE GILCHRIST HOSPICE CARE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 X M 2 D F Months Days Hours Min 1170971933 **Director** 219-28-1690 Usual Residence of Decedent 28a-f show 10a. State 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17 BRANCHWOOD COURT 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify. Completed 3 Widowed 4 Divorced WHITE Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nr
any injury or other traumatic event, the Medic (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) STRUCTURAL ENGINEER ENGINEERING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HARRY SHUMAN SARAH EISENBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIAN SHUMAN/WIFE BRANCHWOOD COURT, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/29/2010 BALTIMORE HEBREW CEM: REISTERSTOWN, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2X No |2 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hosbice Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No Director A Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Cettifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. y one) certifie nature and tit 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 6701 N. Ch 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

State Registrar

only one) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type,

DHMH 17 Rev 7/2009

29d. Date signed (Month, Day, Year,

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Richard Scilipote, Jr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Examiner 4c. County of Death Good Samaritan Hospital . Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1**X** M 2 □ F 55 June 20, 1955 Director 215-68-2041 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f Baltimore Parkville MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or Funeral 2925 Cub Hill Road 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Black, White, etc ₽ 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Maryland 21215 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housing Authority Carpenter 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John R. Scilipote, Sr. Genevieve Wiegel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2925 Cub Hill Road-Parkville, Maryland 21234 19a. Informant's Name/Relationship (Type, Print) Genevieve Scilipote-mother timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel and Cremation Belair 1 Durial 2 Dremation 3 Removal from State 12/30 Forest Hill,Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arrhuthmia dispase or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Line as 4 Pregnant at time of death Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) signed by the a 1 ☐ res ∠ ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 M Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 M No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA ၉ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Y Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Cortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and plane, and due to the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062689 December 24, 2010 x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blyd Bathmore, MD 21239 Kathleen L. Shaffer MD 31. Date filed (Month, Day,-Year) State Registrar DFC.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 25,2010 3:10 Helen A. Sokolowski Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** oct. 16,1928 1 □ M 2 🔀 F Months Days Hours Min Mary land 217-24-0197 Yrs Director 82 Usual Residence of Decedent 28a-f sho 10a. State 10b. County artment of Health and Mental Hygiene. ortants If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 🗆 Yes 2 🔀 No Baltimore MD Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 E. Joppa Road Apt. 2103 USA 21286 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married filed within 72 hours after 1 ☐ Yes 2X No Specify: white Specify: 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Social Security Elementary/Seconday (0-12) College (1-4 or 5+) Key Punch Operator Administration 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ance. ပ္ John Sokolowski Stephanie Banachowska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2414 Perring Woods Road-Baltimore, Maryland 21234 Frances S.Kahler-neice 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery crematory or other place)
Evans Funeral Chapel
and Cremation Ser Belair ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Dec.27,2010 Forest Hill, Maryland 4 Donation 5 Other (Specify) Signedure of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🗶 No Pregnant at time of death Month Day Year 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No Yes 2X No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 Division of Vital Records, within 24 hours after do

To the Funeral Directo

completed filled in by t

Maryland 2121

Baltimore,

2010

E

31. Date filed (Month, Day, Year) State Registrar

29a Certifier

29b. Signature and title

ss of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 27 SPROUSE 20 TO MARY BELL 11:00a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE MIDDLE RIVER 2232 VAILTHORN ROAD 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday 1 □ M 2 🕱 F Months Hours 029497 1922 VIRGINIA 88 Director 214-14-4054 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director BALTIMORE MD MIDDLE RIVER 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2232 VAILTHORN ROAD 21220 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 0 PEDIATRIC NURSING HOSPITAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HENRY CHILDRESS LILLIE VERNON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES SPROUSE SR GRANDSON 2232 VAILTHORN ROAD BALTIMORE. MD 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 MBurial 2 Cremation 3 Removal from State ò BALTIMORE, MD HOLLY HILL CEM 12/30/10 4 Donation 5 Other (Specify) injury 21. Signature of Fundral Service Licence 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME CHESACO AVE BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final .Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Esquentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury executed burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last ettending physician or use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death the detached 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 120 has autopsy perform 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 A Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 27,2010 completed cause of death (Item 23a) (Type, Print) Newlan MD 3512 31. Date filed (N Year, State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ZUIU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20**1**0 December 10:00 PM MARIANNA TOMKO, S.S.N.D. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County MARIA HEALTH CARE CENTER Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 Months Days Hours New Jersey 217-58-3551 Director 92 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or non-one. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Baltimore County Baltimore 10f. Zip Code 10g. Citizen of What Country? Funeral 6401 North Charles Street 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married 1 Yes : 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Teacher Parochial Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tomko Andrew Hornyak Mary 19a. Informant's Name/Relationship (Type, Print)Pers. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 North Charles St., Baltimore, MD 21212 Sr. Bernice Feilinger,SSND 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Villa Maria Cemetery 12/29/2010 4 ☐ Donation 5 ☐ Other (Specify) Glen Arm, Maryland . Signaturum Fun ya Servi A Sicansye MITCHELL-WIEDEFELD FUNERAL HOME, IN 6500 York Road, Baltimore, Maryland Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CARCINEM 1 UTERIN enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months
1 Yes 2/ No
9 Unknown Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, To Be 26. Place of Death (C only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner Ceath 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature poncu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 7505 Osler Drive, Towson, MD 21204 Carmody, Francis X. 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items# 23a, 25, 27, 28a-f, per me, 9917 7-13-11 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December PM 2010 paa Medical Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Buyien Himore N/A If Under 24 Hrs. . Age (In yrs. last birthday) If Under 1 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**X**XM 2 □ F Months Days Hours (Month, Day, Year Director 220-22-3925 82 PENNA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits MD. N/A BALTIMORE 1 X Yes 2 ☐ No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5220 YORK RD. 21212 items filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: BLACK Completed 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER STATES ENGINEERING Be 17. Father's Name (First, Middle, Last) UNIC 18. Mother's Name (First, Middle, Maiden Surname) မ LILLIE M. TEAGLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA ANDERSON (DAUGHTER) 2914 OAKFORD AVE. BALTIMORE, MARYLAND 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Crep ation 3 
Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST VETERANS 1-5-2011 OWINGS MILLS, MARYLAND Sign Prineral Service License D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. AUTANOE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Enter the dis shock, or heart failu Immediate Cause (Final Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Head Injuries with Complications Respirators ⊕nysician/ disease or condition resulting in death) Medical Due to (or as a conse uence of): Examiner Protomorno Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Ducito (or as a consequence or). CENTIFICATION APPROVED BY MEDICAL EXAMINER within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be ex Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Atheroscleroptic Cardiovascular Disease 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical examiner?

1 X Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Mann of Death 28c. Injury at work?
1 ☐ Yes 2 🗷 No 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 Pending subject fell down steps fd 11-24-10 Unk 2 X Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) outside steps in front of daughter's home 28f. Location (Street and Number or Rural Route Number, City or Town, State) **Pelham Ave.** determined Baltimore, Md Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) KES - 000 Vecember 22, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore, MD 21224 W.D 4940 Eastern Ave 31. Date filed (Month, Day, Year) **DEC 2 9 2010** 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ December 19, 2010 Hattie Terry Sue 6:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arlington West Nursing Home Baltimore 8. Date of Birth April 6, 1918 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Min. 1 □ M 2 □ Hours 92 224-14-7867 Virginia Director Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3939 Penhurst Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, δ 1 Never Married 2 Married ☐ Yes 2 🖾 No Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: "natural", 3 X Widowed 4 □ Divorced Specify: Black Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic e Matt Jordan Pearl Tuck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Wagstaff 65 Nursey Lane, York, PA 17404 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 R Burial 2 Cremation 3 Remova from State 4 Donation 5 Other (Specify) Baptist Charel Ceme 12-24-2010 South Boston, VA 21. Signature of Funeral Service License Jeffress Funeral Home 22. Name and Address of Facility 2000 North Main Street, South Boston, VA 24592 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Medical Cardiac arrythemias disease or condition 100 minuson resulting in death) Due to (or as a consequence of): Examiner therosclerotic heavet dispase 10415 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events 11 Hypernension attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Dementiq 5-428 Division of Vital Records, P.O. Box 68760 as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 1 ☐ Yes 2 ☑ No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 1 🖸 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: the Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DESAIND

31. Date filed (Month, Day, Year)

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29c. License number

D 30494

Catonsville MOVIZZE

29d. Date signed (Month, Day, Year)

12/10/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 1 U Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 1241AM d-ok Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Location of Death **Examiner** Bayvier 3att imore 8. Date of Birth (Month, Day, Year) 07/14/1927 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Maryland Months Days Hours Min. 1 M 2 X F 212-26-5050 83 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified 1 Yes 2XXNo Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 Funeral 33U.S.A. 21221 1450 Galena Road iral", or items? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2XXXNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify White "natural" 3 X Widowed 4 ☐ Divorced marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Endres Marie Anna Leo Pilachowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) S permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 9684 Lake Douglas Place, Orlando, Florida 32817 Angela Fernandez (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. 12/31/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) <sup>22. Name and Address of Facility</sup>
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 Signature of Funeral Service Licensee 23a. Part 1. E. in the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme de Cause (Final disse or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to or as a consequence of): if any leading to immedicause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🖵 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending Investigation Could not be within 24 hours after death

To the Funeral Director: A 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and itle of certifier of person who completed cause of death (Item 23a) (Type, Print) Eastern Aue 4940 earborn

Registrar DHMH 17 Rev 7/2009

State

Box 68760

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d, Date signed (Month, Day, Year)

29c. License number

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760

Physician/

Medical

Director

Funeral

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Completed

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**Examiner** 

**Funeral** 

Director

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27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at

and Mental Hygie is marked other

permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once.

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Physician/Medical

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Completed

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Certificate:

Medical

29b. Signature and title of certifie

filled in by

the Maryland

within 72 hours after death with

Maryland 21215-0036

been signed by the attending physician and should be detached for use as the burial-transit Division of Vital Records, page 2 s this certificate Hospital within 24 hours a

State Registrar

DHMH 17 Rev 7/2009

Barbara Supanich, RSM. M.D. 1500 Forest Glen Rd. Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

Supanich RSM MID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:48 PM 010 RUTH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MD BALTIMORE CITY BALTIMORE, GOOD SAMARITAN HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 🗆 M 2 🖬 Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Funeral Director 1 Yes 2 No imore MD OWSON 10g. Citizen of What Country? 10e, Street and Numbe 10f. Zip Code items 23a USA 21239 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian the Medical Examiner Armed Forces Black, White, etc. ь ģ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Blac "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT#se retired) al Hygiene. Elementary/Seconday (0-12) Collegg (1-4 or 5+) permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route N andallstown, MD 21/83 Baltimore, Place of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License C. Greene Funeral Services Randallstown, mD 23a. Part 1. En et the disease, or complications that caused the death. Do not enter the mode of dying, such as carriac or respiratory arrest shock, or art failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ RENAL END STAUE DISEASE disease or condition resulting in death) Medical Examiner ULMONARY EM BOLISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): the attending physician and ned for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year 1 L Yes 2 L 9 D Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown HYPERTENSION, DIABETES MELLITUS, 24b. Were autopsy findings available prior to completion of cause of death? CEREBROVASCULAR ACCIDENT After this certificate has autopsy performed' 2 **N** 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No ရ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide s after death Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4  $\square$  Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Signature

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2010

31. Date filed (Month, Day, Year

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DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December 2010 <u>Ruth Elsa Weston</u> 8:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1341 Crows Foot Road Marriottsville Howard Social Security Number 8. Date of Birth (Month, Day, June 3. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)

Maryland If Under 24 Hrs. **Funeral** 1 □ M 2 🛛 F Days Months Hours 214-03-9986 Yrs Director 92 June Usual Residence of Decedent 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Marriottsville Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21104 USA 1341 Crows Foot Road 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Music Pianist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Norma Alberta Lentz Philip John Hauswald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 1340 Crows Foot Road Marriottsville, MD 21104 Carlyn Aliah/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 D Removal from State cemetery, crematory or other place) Final Journey Crematory 12/28/10 Woodbine, MD 4 Donation 5 Other (Specify) Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine ary, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) Pregnant at time of death the 9 Unknown 9 I Inknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2 No Yes director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Example 1 (a) Example 2 (a) Example 2 (b) Example 2 (b) Example 2 (c) Ex 29a. Certifier (Check Catifying Nurse, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one To the 29b. Signature and title DECEMBER 23, 2010 30. Name and addres of person who cor GLENWOOD STE SCOTT MAUREN MA ROUTE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For amend item 2 per doc g911 1-24-11 vt

Certificate of Death

Reg. No. 2. Date of Death
Month 23 Day 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** PM 2000 12 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARE HOMEWOOD BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F Months Days Hours Min. 88 146-18-8981 Director 129 11927 PENNSYLVANIA Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Yes 2□No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. Director BALTIMORE MD 10e. Street and Number 1St Flock 10g. Citizen of What Country? U.S.A. MATTHEW Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Na Yes 2 No 1942 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>ک</u> Specify: Specify: BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SHIP WELDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLAYBORNE WASHINGTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) & 12 18 STREET, BALTIMORE, MARY/AND
Date | 20c. Location - City or Town, State CARMENTA WHITE Daughter 120b. P 320 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State GARRISON FOREST 01/06/2011 OWINGS MITTS, MARYAND CEME 4 ☐ Donation 5 ☐ Other (Specify) C. JUNES FIH, P.A 21. Signature of Funeral Service Lie DERRICK AVE. BALTIMORE, MARYLAND 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Meta Sle Cell **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death
9□Unknown Month Day Year 5 ☐ Other (specify) signed by the a □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☐ NO 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After To the Hospital or Attending 5 Pending investigation death. 1 🗌 Yes 2 No after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 2 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3010 1843P M 1ams Cia Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Regional WICOMIC Medical cento If Und 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 NF Months Hours Min. **Director** Usual Residence of Deceden 28a-f shov 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Funeral Director 1 ☐ Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country items 23a 21817 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 2 1 No ☐ Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 4-55T Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname ၉ 11,ams nsom ames 19a. Informant's Name/Relationship (Type, Print) 21205 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🧗 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 3 2010 21. Sig vur f Funeral Se vice License Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ MYOCARDIAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ATHEROSCIEROTIC YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No cate has been signed by the atte page 2 should be detached for a Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown STAGE RENAL Completed DISEASE 24b. Were autopsy findings available prior to completion of cause of death? PERICARDIAL 24a, Was an autope performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 \( \text{Yes} 2 X No မြ 1 Hapatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending work? 2 🗌 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONALD WOODBROOKE DR IRAUITZ MID SALISBURY 1665 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DHMH 17 Rev 7/2009

H

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Arthur Geiseima		State of Maryland / Department of F  - For State Certificate of D			2010 \$1090
Physici		1. Decedent's Name (First, Middle,Last)	2.	Reg. No.  Date of Death  Month Day	3. Time of Death
Medical Exami	ner	ARTHUR WILSON GEISEMAN, VI 4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death	December 21, 20	0925 hrs County of Death
			Sykesville		arroll
Funeral			If Under 1 Year   If Under 24Hrs.   8 Months   Days   Hours   Min.	. Date of Birth (MM/D	D/YYYY) 9. Birthplace (State or Foreign
Director		205 16 4059 11 M 2 F 85 Yrs.	World's Days Flours Will.	JULY2719	
*03		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
. å	ō	MO CARROLL SYKESI	ILLE		1 Yes 2 No
Maryla r 28a-f	Director	10e. Street and Number	Of. Zip Code	10g. Citize	en of What Country?
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Heatht and Mental Hygiene.  unt: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	al Di	710 OBRECHT ROAU  11. Marital Status	21784 eccedent of Hispanic Origin? (Specif	h Van ar No. 11	4. Race - American Indian, Black,
eath w	Funeral		specify Cuban, Mexican, Puerto Ric		White, etc.
after d	by Fi	3 Widowed 4 Divorced If Yes, Give Year 1946 1 Yes	es 2 No specify:	S	pecify: WHITE
hours "natur	ted		Usual Occupation (Give kind of work of working life. DO NOT use retired)		LBUQUERQUE
036 thin 72 ne. than	Completed		6ATIVE JOURNAL 18.Mother's Name (Fin		-
11215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner					
2121 ald be f Mental marke	To Be	ARTHUR WILSON GEISEMAN, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ar	ddress (Street and Num or or Rura	EISHER Route Number, City	GONE
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If item 27 is marked other than injury or other traumatic event, the Medica		HELEN E. GEISELMAN/WIFE 1597 H	COMELAND DR 3	B SYKESI	
s l and of Heal		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition crematory or other	n (Name of cemetery, Da	ate 20c. Lo	ocation - City or Town, State
Limo . Page ment c		4 Donation 5 Other Specify: SOUTH CAR	2011 Crem. 12/24	NW OICE	VFIELD, MO
Balti permit. Departm Imports		10/1/1	e and Address of Facility	ZUMBRUN	1 1=1+ 4 mov 60. 25RUNG-MO 21784
Physician		23a. Ratt. Enter the disease, or complications that caused the death. Do not enter the			
Vedical. Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a, Head Injuries			Death Death
To week		or condition resulting in death)  Due to (or as a consequence of):			
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Ulsuses or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			4
50, te be executed tysician and turial - transit		d			
G8760, certificate be executed nding physician and issented is as the burial - transition is as the burial - transition is a second or the second or transition or transit	Medical	UNPENDED			
	Ž.	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal of the past 12 months?	death 3 Ectopic pregnancy	177	Date of delivery Ionth Day Year
Box 6876 e death certificat the attending phy	Physician/A		(Specify)		
hed the		Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?
i, P.O.	Completed by	Seizures, dementia		1  Yes 2 <b>✓</b> I	No 3 Probably 4 Unknown
ords w requisite provided	plete			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	E O			performed? 1 ✓ Yes 2 No	death? 1 ✓ Yes 2 No
n of Vital Records, ling Physician: The law requiri After this certificate has been si funeral director, page 2 should t	å	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check only  DOA Other  Nursing Ho		
Of Vi	임	Tes 2 No		ne 5 Residence  I. Describe how injury	ce 6 🗸 Other: Scene
_ # · ^ 2	Certification:	27. Manner of Death  1 Natural 5 Pending 2 ✓ Accident Investigation  28a. Date of Injury (Month Day Year) Dec 21, 2010  28b. Time of Injury 0915 hrs	1 Yes 2 ✓ No Sul	bject fell	
Division pital or Attendion ours after death, neral Director: A	tific	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, s		or Town, State)	Number or Rural Route Number, City
Ospital bours uneral		4 Homicide determined (Specify) Nursing Home  29a Certifier   Cartifier Branch   Cartifier   Cartifier		Obrecht Road, Sy	
Di To the Hospital within 24 hours a To the Funeral I	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigation,			
To wit	¥	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
		anetz.	O.C.M.E.	Dece	mber 22, 2010
Y\		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 21201		
st	ate	31. Date filed Month. Day, Xear Queen Registrar's Signature		======	
Regist	rar	31. Date filed work Day Year 2010 Registrar's Signature	7		
DHMH 17 Rev 1/20	001	ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 11:55 pM Lillian Louise Woods Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Montgomery Aspenwood Senior Living Silver Spring If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🖾 F Days Hours 047647 1920 Director 579-14-5407 90 DC Usual Residence of Decedent 28a-f shov Ħ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director other traumatic event, the Medical Examiner must be notified MD Silver Spring 1 Yes 2 XNo Montgomery 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 20906 United States 14400 Homecrest Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married 9 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rose Pruitt Harry E. Kendrick, Sr. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St 3032 Harbin Field Ellicott City, MD State, Zip Code) D 21042 Richard Woods Jr. - Son 1 and 2 s of Health item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 12/30/2010 Silver Spring, MD <sup>22. Name and Address of Facility</sup> Harry H. Witzke's Family F.H.Inc 4112 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Service License M00845 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Pnysician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cardiomyopathy 2 years Sequentially list conditions. Examine Durate for 68 a nonecourings of cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burlal-transit that initiated events Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live Birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo
9 Unknown Month Day Year Other (specify) Pregnant at time of death signed by the a 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signage 2 should b 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24543 December 29, 2010

Registrar

State

O

3305 N. Leisure World Blvd.

32. Registrar's Signature

Silver Spring, MD 20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

James A. Rossi,

DEC 292010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 **1 –** For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 625 AM Medical give street and number Examiner 05 8. Date of Birth 7. Age (In yrs. Birthplace (State or Foreign Country) **Funeral** 1 ▼M 2 □ F Months Hours **Director** Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 No 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🗷 No Specify: If Yes, Give 31ac Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be ther's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen MD21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or hear failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a co sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ener On serial Scause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) signed by the a ld be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one, Be Hospital: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural
Accident
Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Ttem 20b per fh e910 12-29-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ non Month 2090 8:30 PM December Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Center och Raven Community Living NIA 139 Himare 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 M 2 □ F Months Days Hours Min (Month, Day, Year) Director MD Usual Residence of Decedent 28a-f show 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director HIMOre MD 1 Yes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral USA Northern or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Xyes 2 No
If Yes, Give
Year or Dates. by Black, White, etc. 1 Never Married 2 Married 72 hours after Maryland 21215-0036 Glack 1 Yes 2 No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any Injury or other traumatic event, the Medical Exan 3 Widowed 4 Divorced Specify. Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Building Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Manufacteurno Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Edward Willis Ihelma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Willis/ Windmill Chase, Apt. L )auanter Sparks, MD 21152 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 2011 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Dwings Mills, MD Garrism Forest 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses vaughin C. Greene Tineral Services 22. Name and Address of Facility au 8 70 01150WL MD 21133 oad Kal 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between ancer Immediate Cause (Final AT sophagean Onset and Death 1etast Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or impury Due to (or se e nonsequenne of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death Year Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No 2 4 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **V** No HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 010 41 36 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 900 Bal Boul Loch 3 aven JEDVA Mary and Utimove 31. Date filed (Month, Day, Year) State DEC 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	ı yıaıı		tificate of L			Reg. N			
	Physicia	n/	1. Decedent's Name (First, Middle Joseph R. Whe1						2. Date of Dea Menth 22		Î'O Year	3. Time of 335 A	
	Medic Examin	al	4a. Facility Name (if not institution,	give street and number)	4b. City, Town, or Location of Death			_	c. County of Death	1			
5	<u>ک</u>		629 Camelot Dr  5. Social Security Number		(In ure la	st birthday)	Be1 A	Air If Under 24 Hr	s. 8. Date of Birt	Harford  h g. Birthplace (State or Foreign			
3:359	Funeral Director		219-03-8953	1 X M 2 □ F	92	Yrs.	Months Days	Hours Mir		191	8 Coi	intry) MD	
$\mathcal{N}$	nd show at	៦	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside Cit	ty Limits
(A)	Maryla 28a-f s otified	Director		ford	Ab	ingdor						1 🗆 Yes	2 ₹ No
0	with the 23a or ust be n	Funeral D	10e. Street and Number 309 Tiree Ct	#101			10f. Zip Code 2100	09		10g. C	itizen of What Co	untry?	
22, 201 5-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 💆 Mar 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates.		1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		Specify Yes or No- erto Rican, etc.)		14. Race - Amei Black, White Specify: Whi	e, etc.	
6	72 hou 72 hou "natu	Completed	15. Deceder (Specify only highe	nt's Education st grade completed)		(Give	dent's Usual Occup kind of work done of OO NOT use retired)	during most of w	orking	16b.	Kind of Business	industry	
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35	be filed lental Hy rked oth	To Be	17. Father's Name (First, Middle, I Thomas Whelan	ast)				18. Mother's N Neenah	lame (First, Middle, McKone	Maide	n Surname)		
	12 should be filed ith and Mental Hy 27 is marked off traumatic event	8	19a. Informant's Name/Relations A. Marie Whela						Rural Route Numbe Abingdon			Code)	
	age 1 and and of the set of Hez		20a. Method of Disposition  1  Burial 2  Cremation 4  Donation 5  Other (5		0	emetery, cre	osition (Name of matory or other place Crematory		Date 23-2010		Location - City or		
() rition	permit. Pa Departme Importan any injury		21. Signature of Funeral Cervice I		Ва	2	2. Name and Addre	ss of Facility So	chimunek	Fun	eral Hom	e of Be	elAir
		Н	Inc 610 W. MacPhail Rd BelAir, MD 21014  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
	Physician/		Immediate Cause (Final disease or condition resulting in death)	a. END	50	1GE	RENAC	DI	SEASE			Onset and I	
2	Examiner		Sequentially list conditions,	Due to (or as a	consequ	derice oi).	322						
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W. P.	ate be ohysicik	edica		d									
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SE	res that the signed by	d by Ph	Part II. Other significant conditi	ons contributing to death bu	it not res	ulting in the	underlying cause g	iven in Part I.	23e, Did to		o use contribute to	the cause of d	
F	The law requires tate has been signage 2 should b	Completed by							24a. Was auto perfo		prior to death?	topsy findings completion of o	available cause of
	sician: The law certificate has birector, page 2 s	Be Co	25. Was case referred to medical				26. F	lace of Death (C	1 L Yes	2 X	No 1 Yes	s 2 No	
77:// 3	Physici Physici this cer ral direc	은	examiner? 1 Yes 2 No			ER/Outpation	ent 3 DOA Oth	4 L Nursin	Home 5 Resident			cify)	
1	nding F nding F tth. : After	cate	27. Manner of Death  1 Natural 5 Pendi 2 Accident Invest		Year)	injury	wor		28d. Ďescribe l	10W IN	ury occurred		
	DIVISION OF WIGHT  Tal or Attending Physician: safer death.  al Director: After this certific ed in by the funeral director.	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 280 Place of Injur	ry - At ho . <i>(Specif</i> )	ome, farm, s	reet, factory, office		28f. Location (S City or Tov		and Number or Ru ite)	ral Route Numi	ber,
	To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical	(Check 2 Medical	p Physician: To the best of a Examiner: On the basis of exp Nurse Practioner: To the b	aminatio	n and/or inve	stigation, in my opin	ion, death occurr	ed at the time, date a	and pla	ce, and due to the	cause(s) and ma	anner stated.
	To the within 2 To the comple	2	29b. Signature and title of certifie		7	, ,	29c. Licens				Date signed (Mont		
1 )			30. Name and addjess of person	who completed cause of de	eath (Iten	23a) (Type,	Print)	Mala	N TIMA			711	193
1	\ Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signa	ture	WEYVE	MEYK	D TMG	// /	u/1, / 1	2 610	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JTIHW Physician/ Month ATHERINE 3AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARWOOD ANNE MANDRIN HOUSE ARUNDEL 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year \_ If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. MARCH Day KENTUCKY 7930 402 40 7470 80 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1X☐ Yes 2 ☐ No COTTAGE CITY MD. P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4142 BUNKER HILL ROAD #315 20722 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give X
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRACTICAL NURSE PRIVATE n and Mental Hygier 7 is marked other t Be permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CLOVIS PERKINS MARION THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARLENE HOPKINS/SISTER 4012 20th ST. TEMPLE HILLS, MD. 20748 20a. Method of Disposition 20c. Location - City or Town, State 20b Place of Disposition (Name of Kee) Date 1 Burial 2 K Cremation 3 Removal from State RIVERDALE, MD. CREMATORY 12/29/10 4 ☐ Donation 5 ☐ Other (Specify) 20010 21. Signatur o Funeral Service Licensee 22. Name and Address of Facility WATSON F H 3435 14th ST N.W. WASH. DC. 23a. Part 1. Eleter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Exami 3THMA Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year signed by the aid be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has autopsy performed Yes 2 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) MANDRIN 1 Tyes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at work? Certificate: Housc within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

29b. Signature and title of certific

31. Date filed (Month, Day, Year,

29

D

backs

32. Registrar's Signature

29c. License number 8118703

30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)
TENEVIEVE LIGHTFOOT-THYLOR, LYS DEFENSE HWY, ANNA POLIS, M-D, 2140)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22<sup>Day</sup> Physician/ RODERICK WATSON DEC 2010 05:32 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗀 53 MAY" 5<sup>Day,</sup> 1°9'5 7 N.C 84 **Director** 577 7713 Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Director MD. MONTGOMERY TAKOMA PARK 1 Ty Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6418 4th **AVENUE** 20912 USA العا", or iten ا Examiner ا 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 XNo
If Yes, Give
Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK "natural", 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry
WASH. ADVENTIST (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOSPITAL the TRANSPORTER Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental titem 27 is marked o ၉ Page 1 and 2 should be ANNIE KIRBY OSLOW WATSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6418 4th AVENUE TAKOMA PARK MD. 20912 THOMASINE WATSON/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Reverse) Reverse Reverse 20c. Location - City or Town, State Date † † • 1 Burial 2 X Cremation 3 Removal from State permit. Page Department Important: I RIVERDALE MD. 4 Donation 5 Other (Specify) 12/27/10 CREMATORY 20010 Sign tue of Funeral Service Licensee 22. Name and Address of Facility WATSON F H 3435 14th ST NW WASH. DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a of insequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events.) Examine Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic preging 5 ☐ Other (specify) Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy eral Director: After this certificate I filled in by the funeral director, pag 2 N 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
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Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar (Month, Day, Yes

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26, 2010 December Reta Justine Winters 08:15 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Fairfield Nursing Center Crownsville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Country) Canada Months Days Hours September 28, 1915 Director 084-14-8580 95 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Gambrills 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2235 Dairy Farm Road 21054 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ٥ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Baltimore City Department of Social Services 16a. Decedent's Usual Occupation should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Case Worker Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 John Petrosky Marie Breynet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Carol Aileen Norkus/Daughter 2235 Dairy Farm Road, Gambrills, Maryland 21054 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) December 29 Parkwood Cemetery 2010 Baltimore, Maryland 21. Signature of Funeral Service Lisensee 22 Name and Address of Facility al Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Exaren M00672 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ arkenen disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day signed by the at d be detached for ☐ Pregnam ☐ Unknown 1 ☐ Yes ∠ y 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed? death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate completed filled in by the funeral director, page 1 Yes 2 No Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) ည 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 - Residence 6 - Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 28/2010

DHMH 17 Rev 7/2009

State Registrar 208

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 24 Year Zojo WITTE Physician/ 5: 10 P M HELMA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL 9. Birthplace (State or Foreign Country) Maryland Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 TF 218-84-3375 50 Director February 8,1960 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Dundalk 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 2902 Dunmurray Road Apt. A 21222 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 🔀 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 12 years College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John F. Roberts Shirley Giddings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health item 27 David Evans Son 7931 Lynch Road, Dundalk, Md. 21222 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite December cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 27, 2010 Name and Address of Facility Connelly Funeral Home Of 7110 Sollers Point Road, 21. Signature of Funeral Service Life Dundalk, P.A. Dundalk, Md. 21222 23a. P. nt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ACQUIRED PHEUMONIA. COMMUNITY Sequentially list conditions, if any course cause. Enter Underlying Exami and -transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) /sician a e burial-1 Physician/Medical 68760 phys the l attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Pregnant at time of death Month Day Year 9 Unknown P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 RENAL DISEASE END STAGE 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? DIABETES MELLINS 24a. Was an has autopsy page nerformed 2 110 1 🗌 Yes 2 [ Yes Hospital or Attending Physician: 24 hours after death. **Division of Vital** 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No After this c ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completed filled in by the fun 5 Pending work 1 Yes 2 🗌 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: Certifying Nurse P (Check ioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D0060293 DECE MBER

Registrar DHMH 17 Rev 7/2009

State

OLD COURT ROAD. PANDALISTOWN

21133

5401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHMED

LURTUZA

Year,

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John William Watters Sr. 7:30 A M 2010 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Jarrettsville Harford 3239 Sharon Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth Funeral Year 1931 Days Hours Min Apr. 25 Mary land 79 Director 213-20-6153 Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland of Mental Hygene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3239 Sharon Road 21084 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Narried Yes 2 No Yes, Give 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Shop Foreman Town Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked o any injury or other traumatic evenones. မ Richard Wilson Watters Lillian (nmn) Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beulah A. Watters / Wife 3239 Sharon Road, Jarrettsville, Maryland 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Remova from State Bel Air Memorial Gdn 12-27-10 4 Donation 5 Other (Specify) Bel Air, Maryland Name and Address of Facility
MCComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 ature of Funeral Septice Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ failure disease or condition ) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Parkinsonis Exami attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Depression 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 1 Yes 2 No 1 ☐ Yes 2 🕱 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital 1 Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Box 68760 Records, Division of Vital funeral director, completed filled in by the

Baltimore, Maryland 21215-0036

Medical

29a. Certifier

only one)

29b. Signature and the of certifier

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Naguib MD 2 Colgate Dr. Suite 203 Forest Hill mp 21050

Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Dec. 21, 2010

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Arlie Keith William	1	- For State	Sta	ate of	Maryla	nd / De	partme Certifica	nt of I	-lealth	and			giene	Reg. No	. 201		41100
Physician Modical Examine	1	egistrar I. Decedent's Name Arlie K		First, Middle,Last) ith Williams, Jr.								2	2. Date of De Month Decemb	eath			3. Time of Death 2306 hrs
	4	4a. Facility Name (if not institution, give street and number) 8544 Kings Ridge Road							4b. City, Town, or Location of Death Parkville			Death	h 4c. County o				
Funeral Director	5	5. Social Security N 216-82-6		6. Sex 1 <b>∑</b> M	2F	7. Age (In yi 49		day) Yrs.	If Under Months	1 Year Days		24Hrs. Min.				oreia	hplace (State or n untry) Marylan
and show any ncc.	1	Jsual Residence of 0a. State MD	10b. County	imore 10c. City, Town			-	on or Location kville									10d. Inside City Limits  1 Yes 2 No
the Maryland ba or 28a-f sh								10f. Zip Code 21234						_	itizen of What		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	٠L				Armed Forces? If Yo  1 Yes 2 X No  If Yes, Give Year or Dates: 1			If Yes,	S Decedent of Hispanic Origin? (Specify es, specify Cuban, Mexican, Puerto Ricar Yes 2 X No specify:				tican, etc.)	an, etc.) White, etc.  Specify:			ean Indian, Black, Lte
5-0036 ed within 72 hours tygiene. other than "natu the Medical Exar	-	Elementary/Secondary (0-12)			College (1-4 or 5+) N/A			a. Decedent's Usual Occupation (Give kind of value) during most of working life. DO NOT use reting the Employed					d)	c. Kind of Business/Industry  Carpentry			
21215-0036 uld be filed within 7 Mental Hygiene, marked other than ic event, the Medica		Arlie Keith Williams, Sr.							Sano	ther's Name (First, Middle, Maiden Surname)  andra Joan Maddox  Number or Rural Route Number, City or Town, State					Zin Code)		
, MD 2 and 2 shou ealth and N em 27 is n Traumatic	L	Thomas Oa. Method of Disp	Schrei				ner 1	5819	Yorl	k Ro	oad Sp	ark		ryla		52	
Baltimore, permit. Pages I an Department of Hei Important: If ite		1 V Burial 2 Cremation 3 Removal from State						ine Park Cemetery 28, 2010						Woodlawn, Maryland			Maryland
	1	1. Signature of Fur	1100	Jai	A	10-1		22. Nam EN 16	vans	Fun Yor	of Facility neral k Road	Char d I	el & Monkto	Cre	mation Maryla	Se nd	rvices 21111
Physician /Medical xaminer	Т	3a. Part Enter the failule List only mmediate Cause (I	Final disease	a. Inti	raoral Gu	inshot We	ound	enter the	mode of o	ayıng, s	such as card	liac or r	espiratory a	rrest, sr	nock, or hear		Approximate Interval Between Onset and Death
i di	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):																
ted Janusit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):																
O, s be execurations and solutions and burial - tra		UNPENDED		<u> </u>	MENDED												
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Execution	If FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify) 9 Unknown									ay Year							
signed by the detached	1 Yes 2 No 3 Prot																
Division of Vital Records, P.O. B Lat of vaterding Physician: The law requires that the d rs after death.  a) Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached bertification: To Be Completed by Physicians.		5. Was case refer	ed to medical							Place	of Death (C	—	per 1 <b>✓</b> Yes	opsy form <u>ed</u> ?	prid dea		opsy findings available ompletion of cause of s 2 No
F Vital Physician or this certinal director To Be		examiner? 1 ✓ Yes 2	2 No	Hosp	_ ' [ ] "	npatient 2		patient 3	B DO/	4	Other4 N	lursing	Home 5		lence 6		Scene
Ivision of or Attending Pluster death. Director: After lin by the funeral lin by the funeral linguation:		7. Manner of Death 1 Natural 2 Accident	5 Pendi	ng igation	FOUND: Dec 22,	Day, Year)	FOUN 2258 h		ry 280		yatWork? es 2. ✓ No	ls.	8d. Describe ubject sh		jury occurred		
Division of N  To the Hospital or Attending Ph, within 24 hours after death. To the Funeral Director: After th  completely filled in by the funeral  ledical Certification: T		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building (Specify) Single Family Home							uilding, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8544 Kings Ridge Road, Parkville, MD								
To the Hospital within 24 hours To the Funeral completely filled			Certifying Ph Medical Exan	niner:On		f examinatio											
	2	29b Signature and with of certifier								icense D.C.N	number //.E.				Date signed		th, Day, Year) 10
131	3	Name and addre     Victor Weed	-			e of death (I		111 Per	nn Stre	et, Ba	altimore,	MD 2	1201				
State Registra	3	1. Date filed (Monti	29 201	0 /	32. Re	gistrar's Sign	nature	Ked									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Xuanfang Zha 4:45 A M December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 💢 M 2 🗆 F Hours (Month, Day, Year, Country) **Director** 1965 215-65-0679 45 China Usual Residence of Decedent 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Montgomery Gaithersburg 10e. Street and Number Of, Zip Code 10g. Citizen of What Country? Funeral 437 West Side Drive #304 20878 China Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🛣 No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Research/Development Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cheng Gen Zha Qiaolian Lu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 437 West Side Drive #304 Gaithersburg, MD 20878 Lingling Li/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it injury or 1 Burial 2 K Cremation 3 Removal from State Final Journey Crematorly 12/31/10 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 any MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph. sician/ Metastatic Gastric Cancer disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 ☐ No 3 ☐ Probably 4 🖔 Unknown been signated should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2X No certificate 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 XNo Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) hospice မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Director: After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours af To the Funeral Di completed filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [XCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R120698 December 25, 2010 Nicole Christenson—CRNP 6001 Muncaster Mill Rd. Rockville, MD 20855

Registrar

State

31. Date filed (Month, Day, Year)

29

park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2010 David Linwood Allen 510 M ecember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Penincula Regional Medical WICOMICO 8. Date of Birth
(Month, Day, Year)
1 - 10 - 1935 Social Security Number 6. Sex 1 ▲ M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Country) Director 75 217-30-9704 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No MD Worcester Pocomoke City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 1822 Cypress Road 21851 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed For 1 X Yes 2 I No If Yes, Give 1 r Year or Date 1 r Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Spec Black Force 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Somerset Packing Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Willie Allen Flossie Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Amanda J. Allen/Wife</u> Cypress Road, Pocomoke City, MD 21851 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Trinity UM Cem 12/13/2010 Pocomoke City, MD 22. Name and Address of Facility 917 W. Isabella St Bennie Smith Salisbury, Funeral Home 23a. Part 1. Entekt shock, or bear the disease, or complications that caused the death. Do not enter art failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) sequence of Examiner te Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 2 🗆 No 1 Yes Be ( 25. Was case referred to dical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: ပ္ 1 Inpatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Vatural 5 Pending work Accident
Suicide 1 Yes 2 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year, 00 41 211 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) Fernando Acle St. SAlisbu md 21801 31. Date filed (Month egistrar's Signatur State 4 acks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Edward Sidney 2. Date of Death 3. Time of Death Adams Physician/ Month lo, 2010 December 4:48 Medical 4a. Facility Name (if not institution, give street and number) b. City, Town, or Location of Death **Salisbury Examiner** 4c. County of Death W1COM1CO 118 Emily Drive 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F 02/08/1929 214-30-8728 Director 81 Maryland Usual Residence of Decedent show 10a. State Ħ 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director r than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Maryland Wicomico Salisbury 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 118 Emily Drive 21804 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry 2 should be filed within 72 In and Mental Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) printing press equipment sales/management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Elizabeth Benton Levin Sidney Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sl tment of Health a tant: If item 27 i 118 Emily Dr., Salisbury, MD 21804 Cora Lou Adams/spouse item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 12/14/2010 Signature of Funeral Service rice see Holloway Funeral Home Professional Association Bell R 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line, Immediate Cause (Final Ph sician/ Mueloduse lastic disease or condition resulting in death) Medical Due to (r r as a cons quence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi). or Attending Physician: The law requires that the death certificate be executed ysician and burial-trans Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death 1 Yes 2 No the 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by heart disease 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 
Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director; After 1 Natural 5 Pending 1 🗌 Yes 2 No Investigation 6 Could not be Accident completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D70053 Wu mD December 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) and 21801 100 East Carroll Street chisbury mary 31. Date filed (Month, Day, Year) 32 Registrar's Signature State park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State AMEND#29 coerMD, 12/13/10, EMW, Mo Certificate of Death Registra AMEND#25 perMD, 12/13/10, EMW, Mo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year **Physician** Ashios 3:33 4 M 200 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner of Maryland Daltimore If Under 24 Hrs. 5. Social Security Number 6. Sex If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth Funeral Months Days Hours Min 1**X** M 2□ F 229-21-3470 56 02-02-1954 Director Nigeria Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 X Yes 2 No MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20886 20303 Markettree permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Extrainer Files once. Place. U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer DISA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nwobodo O. Ashiogwu Chiwetaly C. Ashiogwu ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera Ashiogwu (Wife) 20303 Marketree Pl. Gaithersburg, MD 20886 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State **1**2/29/2010 4 ☐ Donation 5 ☐ Other (Specify) Nigeria Family Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility. H. Bacon Funeral Home, Inc. CCOS18 3447 14th St. N.W. Wash. DC 20010 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner carcinoid tumor of the small been 4 Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine The law requires that the death certificate be executed buria! Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burla IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate has birector, page 2 sl 24a. Was an 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) P25252 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hart 21 Fremont 5. Baltimore Ave SOUND

State Registrar 31. Date filed (Month, Day,

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2010 Month Physician/ 21.77 9050 ctab Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner Hoose Asunde Meade Cama 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🗆 M 2 💢 F 9 Months Hours Min. Country) VA 0 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location **Funeral Director** 1 Yes 2 No MD Anne Arundel Millersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8288 Elvaton Road 21108 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 ₩idowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) q <u>Homemaker</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard C. Elmore Vivian Balderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Ellen Berg(Daughter) 8288 Elvaton Road Millersville MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State otuska WARSAW 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses and Address of Facility 721 Elden Street 22. Na VA 20170 Herndon, Adams-Green Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) +05 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director, After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of after death.

Director; After this certificate has autopsy perform death? rmed? 2 **X** No 2 🛱 No 1 Yes Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 4 Nursing Home 5 Residence 6 Other (Specify) Hospica House Other: 2 ANO 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 A Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signa 29c. License numbe 29d. Date signed (Month, Day, Year) 700 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jackie Lee Breeden Month Year 8:50 Am Medical 3010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ocistal Itospice at the Salisbury Niconico Social Security Number 7. Age (In yrs. last birthday) 72 If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 05/15/1938 229-44-9140 1 **X** M 2 □ F Months Min. Days Director Virginia Usual Residence of Decedent 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1X Yes 2 ☐ No Worcester Berlin 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 72 Battersea Road 21811 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

Yes 2 No Black, White, etc. by 1 Never Married 2 X Married 21215-0036 If Yes, Give Year or Dates. Army 1 Yes 2 No Specify. white Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. 12 warehouseman liquor Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kenneth Lee Breeden Ethel Irene Jones injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Miriam Breeden/spouse 72 Battersea Rd., Berlin MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/13/2010 Salisbury Crematory Salisbury, MD nature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LZHRIMRR 151EA5R disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes Yes 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 DINO Other မ HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death
1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 4mil 00058410

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HULAN 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 2010 13:05 BRASURE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WORCESTER BERLIN ATLANTIC GENERAL HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Min 1 ▼ M 2 □ F UNE 30 Director Yrs. DELAWARE 222-18-0605 79 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 35097 LIGHTHOUSE ROAD 19975 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.1951-53 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: WHITE Specify: Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) POULTRY INSPECTOR USDA DEPT. OF AGRICUL. 12 Be any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ൧ CECILE HUDSON **JAMES** L. BRASURE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shand Department of Health ar Important; If item 27 is 35097 LIGHTHOUSE RD., SELBYVILLE, DE 19975 ACHSAH D. BRASURE/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date XBurial 2 ☐ Cremation 3 ☐ Removal from State onation 5 Other (Specify, ROXANA CEMETERY 12/13/10 ROXANA, DELAWARE 21. Signature of Funeral Service License 22. Name and Address of Facility <del>H</del>ASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 Enter the disease, or complications that Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

ediate Cause (Final ase or condition Interval Between Immediate Cause (Final Onset and Death Carlo Viraleo Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exam that initiated events resulting in death) Last Due to (or as a consequence of) ending physician use as the burial Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Perham 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an te has lage 2 s autonsy death? 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 DINO Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 110 10001802 IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1709 Coestal Hyhur, Fen wick Followed, De N. Borodulia, mi

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

**Division of Vital** 

32 Registrar's Signature

			Please Type or Pri						and the same	1 0		
			For State of M	aryland / I	•	artment of F <i>tificate of D</i>	lealth and M	lental Hy	giene <u></u>	UIL	1 41108	
			Registrar  1. Decedent's Name (First, Middle, Last)	Jeath	2. Date of Dea	Reg. No.		3. Time of Death				
	Physicia Medic		James Dominic Bligh	Jr.				Month 12	Day	Year 2010	9:209 M	
	Examin	er		lake				nty of Deat				
	Funeral Director		577-14-0129   1X M 2 🗆 F   93	ge (In yrs. last birt 1	thday) Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) 04/11/1919  9. Birthplace (State or For Country) Washington, D					
	and show	or	Usual Residence of Decedent  10a. State 10b. County				10d. Inside City Limits					
	Maryla 28a-f: otified	Director	Maryland Wicomico		1 <b>K</b> Yes 2							
	th the	al D	10e. Street and Number			10g. Citizen o	of What Co	ountry?				
	ath wi	Funeral	1105 S. Schumaker Drive  11. Marital Status 12. Was Decedent I	Ever in U.S.	13.1	21804	isnanic Origin? (Sne	cify Yes or No-	USA	ace - Ame	rican Indian,	
9036	Tage 1 and 2 should be filed within 72 hours after death with the Maryland thent of Heath and Memtal Hygiene. In: If them 27 is marked other than "natural", or items 23a or 28a-f show in: If then 27 is marked other than "natural", or items 25a or 28a-f show in; or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🛣 Married 1 ☐ Never Married 2 🛣 Married 1 ☐ Never Married 2 🛣 Married 1 ☐ Never Married 2 ☐ Never Married 2 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐	No		f Yes, specify Cuba I ☐ Yes 2 <b>X</b> No	spanic Origin? (Spe n, Mexican, Puerto Specify:	Rican, etc.)		lack, White		
- - - -	72 hou n "nat ledica	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give I	dent's Usual Occupa kind of work done o O NOT use retired)	ation during most of worki	ng	16b. Kind of	Business	Industry	
212	within giene.		Elementary/Seconday (0-12) College (1-4 or 9		insu	•						
yland	id be filed Mental Hy, arked oth atic event	To Be	17. Father's Name (First, Middle, Last) James Dominic Bligh Sr.		ne (First, Middle, Maiden Surname) Jouise Sweeney							
Baltimore, Maryland 21215-0036	ind 2 shouldealth and lealth and sm 27 is mere trauma		19a. Informant's Name/Relationship,(Type, Print) Alice H. Bligh/spouse	MD 2	e, Zip Code) 21804							
timore	t. age 1 a trent of F trint: If ite jury or ott		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemete	ry, cren	sition (Name of natory or other place Cremato:	e)	3/2010	20c. Location			
Ba	permit. Pag Depart ent Import nt: any inj. ry c		21 Signature of Fune A. Wormprov	> CFSP	ff 5	Name and Address OILOWAY F	uneral Ho Hill Rd.,	me Prof	fession	nal A	ssociation	
			23a. Part 1. Enter the disease, or complications that caused	d the death. Do r	not ente	er the mode of dying	g, such as cardiac o	r respiratory arr	est,	210	Approximate	
200	hysician/		Immediate Cause (Final disease or condition	TATIC	_	LIUBR	CAR	CINDU.	A		Interval Between Onset and Death	
	Medical Examiner		resulting in death)  Due to (or as	a consequence	of):			···				
		iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
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68760	tificate ng phy as the	Medi	IF FEMALE:									
Box 6	requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Physician/Medica	23b. Was decedent pregnant 23c. If yes, outcome 1 Live Birth	in the past 12 months?  1								
P.O.	that th ned by e detac	by Ph										
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ဝ၁	has be be 2 sh	Completed						24a. Was a autop	sy		topsy findings available completion of cause of	
ř E	hysician: The law r his certificate has b il director, page 2 sl	Be Co	25. Was case referred to medical			26. Pla	ace of Death (Check		rmed? 2 La No	1 🗌 Yes	s 2/2 No	
<u> </u>	hysici his cer Il direc	일	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSP									
n o	ding P th. After t funera	cate:	27. Manner of Death  1 Natural  5 Pending  (Month, Da		Time of injury	work		28d. Describe h	ow injury occi	urred		
Division of Vital Records,	after death.  Director: After this certificate has been sign in by the funeral director, page 2 should be	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined									
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral di	Medical	29a. Certifier 17 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of a control of the control of	examination and/o	or invest	tigation, in my opinio	on, death occurred at	the time, date a	nd place, and	due to the	cause(s) and manner stated.	
	To the within To the compl	2	only one) 3 Certifying Nurse Practioner: To the 29b. Signature and fixe of certifier	pest of HIV KNOW	reuge, (	29c. License	number		29d. Date sign	ned (Monti	h, Day, Year)	
			10			00	058410	>	12/	12/1	ن	
_	2 mil		30. Name and address of person who completed cause of deficiency was in the complete of the cause of deficiency was a supply of the cause of th	r Jup 1	(Type, F	Print) SAL	05841c	PD	w	218	302	
	Stat			ar's Signature	100	who	3.77					

James D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 4 U 1 U Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December 10 2010 4:55 Sylvia Baer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) **Funeral** 1 □ M 2 🛣 Days Hours larch, By Year) 1923 098-16-0659 87 NewtryYork Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 5955 Quinn Orchard Road 21704 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give 3X Widowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Medical School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot Abraham Shenitzer Rebecca Katz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Lieberman / Daughter 4310 Mountville Road, Jefferson, MD 21755 20a. Method of Disposition
1 ☐ Burlal 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: It any injury or Smithsburg Crematory 12/14/2010 Smithsburg, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee ROBERT E. DATLEY & SON FUNERAL HOMES, 1201 NORTH MARKET ST., FREDERICK, MD 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown ☑ No Unknown been signed by Qther significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case refe Be 26. Place of Death (Check only one) examiner' Hospital 1 🗌 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventional control of the page of examination and or inventional control or inventional control or invention and or inventional 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 31. Date filed (Month, Day, Year) 32. Regist ar's Signature Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:58 A M Elizabeth Frances Beyard 2010 December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Homewood At Williamsport Williamsport Washington County Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Voorl Months Days Hours Min 214-09-1404 92 Director 15,1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d 2 should be filed within 72 hours arier death with the Maryla th and Mental Hygiene.
7 Is marked other them "natural", or items 23a or 28a-f show traumatic event, it was a traumatic event, it was the motified at Director 1 ☐ Yes 2 No Maryland Washington County Williamsport 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16505 Virginia Ave. U.S.A. 21795 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. e Maryland 21215-0036 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify. <u>Ş</u> Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Teacher Department of Heath and Mental Hy, Important: If Item 27 is marked other any injury or other traumatic event. 1000. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley R. Adams Alice Blanche Suman Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael D. Beyard-son 1127 Woodland Way Hagerstown, MD 21742 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory 12-13-2010 | Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Douglas A. Fiery Funeral Home Zone Auto 1331 Eastern Blvd. North Hagerstown, MD 21742 Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause preach line. Approximate Interval Between Onset and Death Immediate Cause (Final NE WHON 16 Physician WONT disease or condition resulting in death) /Medical Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant et time of death in the past 12 months? Month Year P.0. 1 ☐Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by t Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Physician: The Vital 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 **N**No : After this certification of the thick of t 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of 27. Manner of Dear Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending To the ruceprocess within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signati 29c. Lidense number 010 OCTON 30. Name and add 3H-4 32. Registrar's Signature 31. Date filed (Month. Day. Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Maryla									
		•	For State Registrar	Otato of Maryle		tificate of L			eg. No.				
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2. Date of Deat		3. Time of Death			
-	Medic Examin	cal	Richard David  4a. Facility Name (if not institution, give si			4b. City. Town, o	r Location of Death	Dec 4, 2	4c. County of D	09:10 P M			
-	LAMIIII		6406 Chew Road	,		Upper M	arlboro		Prince G				
	Funeral Director			7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 13,	9. 1948 M	Birthplace (State or Foreign Country) aryland			
	and show at	or	Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation				10d. Inside City Limits			
	Maryle 28a-f s otified	Director	Maryland Prince Geo	rge's	Uppe	r Marlboro				1 ☐ Yes 2 XXNo			
	with the 23a or 1st be r	eral D	10e. Street and Number 6406 Chew Road			10f. Zip Code 207	72.	1	0g. Citizen of What				
	items	Funeral		12. Was Decedent Ever in t Armed Forces?	U.S. 13.\	Nas Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-	14. Race - A	Maryland  10d. Inside City Limits  1  Yes 2 XXNo  at Country?  States  American Indian, White, etc.  White  ness Industry  and State Hwy Admin  te, Zip Code)  ity or Town, State  Maryland  3 Old Alexandria  Approximate Interval Between Onset and Death  2  Penny Maryland  Onset and Death  Control of delivery			
Maryland 21215-0036	e filed within 72 hours after death with the Manyland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 → No If Yes, Give XX Year or Dates.	1	Yes 2 X No		110411, 0101,	Specify: W				
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and	e filed ratal Hyged oth ed oth event,	To Be	17. Father's Name (First, Middle, Last)  John William Burrous	ahs Sr		18. Mother's Name (First, Middle, Maiden Surname)  Annie Sweeney							
aryli	1 and 2 should be file if Health and Mental H item 27 is marked o other traumatic ever	,	19a. Informant's Name/Relationship (Typ		19b. Mailir	na Address (Street :	and Number or Rura			Zip Code)			
			Mary R. Burroughs (W	ife)		6406 Chew Road, Upper Marlboro, MD 20772							
Baltimore,	ge 1 and nt of Heal i: If item 2 or other		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State		natory or other plac	ce)		20c. Location - City				
altin	permit. Page 1 a Department of I Important: If ite any injury or of		4 ☐ Donation 5 ☐ Other (Specify)  21. Signat of Funeral Service Licensee	7		n Cemetery  . Name and Addres		0, 2010   Tuneral Ho	Clinton, M me.Inc.6633				
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Box 6876	n certifi ending r use æ	an/M	ZOD. Was decedent pregnant	3c. If yes, outcome of preg	nancy etal death 3	Ectopic pregnanc	cv		23d. Date of	,			
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P.0	s that the gned by se deta	þ	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cause giv	ven in Part I.		. /				
rds,	equire been si hould t	eted				-	-	1 🗆 Ye		Probably 4 Unknown			
Seco	sician: The law is certificate has the law injector, page 2 s	Completed						24a. Was ar autops perforr	y prior t death	autopsy findings available to completion of cause of ? Yes 2 \( \sum \) No			
E	sian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?				ace of Death (Check	1 \(\sum \) Yes 2 only one)		res 2 🗆 NO			
Ž	Physic this oral dire	유	1 ☐ Yes 2 No	ospital: 1  Inpatient 2 [ 28a. Date of injury	ER/Outpatier	ot 3 DOA Other	4 U Nursing Ho		nce 6 Other (Sp	ecify)			
o uo	anding ath. r: After ne fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work		28d. Describe no	w injury occurred				
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  within 24 hours after death.  completed filled in by the funeral director, page 2 should be detached for use as the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (Str City or Town		Rural Route Number,			
_	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2   Medical Examine	cian: To the best of my kno er: On the basis of examinat Practioner: To the best of	ion and/or invest	igation, in my opinio	on, death occurred at	the time, date and	d place, and due to the	e cause(s) and manner stated.			
	To th within To th comp		29b. Signature and title of certifier	440	9-16	29c. License			9d. Date signed (Mo				
				mpleted cause of death (Ite	em 23a) (Time D	rint)	1425	1 [	selumber 6	, 2010			
1	B6		Nicholas A. I	ripleted cause of death (ite	89 26	Washer	d Rd Suit	r 601 (	linton, M	0 20735			
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	barks			<b>\</b>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201<sup>rea</sup> December Gloria Jean Buford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Cheverly Prince Georges Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth Age (In vrs. last birthday) **Funeral** (Month, Day, Hours 1 M 2 St 1922 Prescott, Director June 358-16-1547 88 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director or 28a-f steen or notified a Maryland Prince Georges Capitol Heights 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 1207 Addison Rd. South #459 20743 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) Clothing Manager 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 1 and 2 should be if Health and Ment item 27 is marked other traumatic e Milton Lee Garland Irma Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1207 Addison Rd. South #353 Capitol Heights, Md. Mary Buford Howard / Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr. Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Dremation 3 Removal from State 4 Donation 5 Other (Specify) 12/14/2010 Riverdale Park Riverdale, Md. Signature of Funeral Service Lice Name and Address of Eacility Alexander S. Pope, P.A. 5538 Mariboro Pike/ Forestville, Md. 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last the attending physician ned for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 9 Unknown should be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/X No certificate has neare 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: Certificate: To 1 ■ npatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d, Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on the 29b. Signature 2 MD (Item 23a) (Type, Print) who completed cause of death W @5 ITKIAS rince DEC 1 4 2010 State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

#20bac Per FH 6911 119/2011 1H
State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year HERBERT J. BASS M 12/4/2010 0856 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death PRINCE GEORGE'S COUNTY HOSPITAL CHEVERLY PRINCE GEORGE'S . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/10/1936 Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 F Months Days Hours Min. Director 225-42-7147 72 Norfolk Usual Residence of Decedent ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10414 Pookey Way 20774 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatin amount. 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Worker US Post Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Elijah Bass Margaret White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reuben G. Bass / Son 641 Nichilson Street NE Washington, DC 20011 20a. Method of Disposition 20b Place of Disposition (Name of Galters, collate) Date S11ver Syring and 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Mt. Olivet 12/15/2010 | Washington, DC Signature of Funeral Service Licer 22. Name and Address of Facility Alexander S. Pope Funeral Home M0108 2617 Pennsylvania Ave. SE Washington, DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the bunal-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed' Yes 2 No 2 No Hospital or Attending Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 1 No ည 1 Inpatient 2 TR/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes Accident Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) completed cause of death (Iteh 23a) (Type, Print) Name and address of person w 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 4 2010 Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

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4110	Examin	er	4a. Facility Name (If 5hady 65. Social Security N	orove A	ive street and number dv 2 x 4 5 +	1.1			ckv	ation of Death	8. Date of Bir		County of Deat	
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nge 215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ሺ Never Marr 3 □ Widowed	ried 2  Marrie 4  Divorced	d 12. Was Deceder Armed Forces 1  Yes 2 If Yes, Give Year or Dates	s? <b>X</b> No	If	Yes, specify (	Cuban, Me	exican, Puerto	ecify Yes or No- Rican, etc.)		Black, White	e, etc.
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50 /	d be filed vental Hygarked otheritic event,	To Be	17. Father's Name ( Robert		n Akame						e (First, Middle, ne Emi			
$\kappa e'$ , Man	nd 2 should ealth and N n 27 is me er trauma		19a. Informant's Na Nancy N		(Type, Print) (Daughte	r)	19b. Mailin	g Address (Str	reet and N	ife C	ir. Ga	ith	ersbur	o Code) MD. g 20886
$AL_{\mathcal{RM}}e$ , $50$ , Baltimore, Maryland	. Page 1 аг ment of H. tant: If ite jury or oth			,	Removal from Sta	ate C6	emetery, crem abon		place)	12-3	27 <b>–</b> 10	Gab	ocation - City or	ica
Balt	permit. Depart Import any inj		21. Signature of Full Firming	1 -1	4		90	Name and Ad 08 Ker	ddress of ned	Facility Hur y St.	N.W.	era Wasl	h, Home	. 20011
			23a. Part 1. Enter t shock, or hea	the disease, or ceart failure. List on	omplications that caus y one cause on each	sed the death line.	n. Do not ente	r the mode of	dying, su	ch as cardiac o	or respiratory ar	rest,		Approximate Interval Between
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_	ate be exe physician a the burial-	edical E	resulting in death)	Last	Due to (or a	as a consequ	ence oi).							
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. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi		IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcor 1 ☐ Live Birt 4 ☐ Pregnar 9 ☐ Unknow	t at time of d		Ectopic preg Other (specif	nancy (y)				23d. Date of de Month	blivery Day Year
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Divisi	al or Att s after d il Directo ed in by t	Certificate:	4 Homicide		28e. Place of	Injury - At ho etc. (Specify)	me, farm, stre )	et, factory, of	fice		28f. Location ( City or To			iral Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 William McRene Blakeney Dec. 16:30 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1931 South Carolina 1 🖾 M 2 🗆 F 251-46-7766 79 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State hours after death with the Maryland Director Capitol Heights 1 X Yes 2 No Maryland | Prince George 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20743 United States 1207 Addison Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed the Medical 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 72 and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Silk Presser Private 12th traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve 2 Estall Robinson Bishop Blakeney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michele Blakeney - Daughter 1154 4th Street NE Washington, DC 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1  $\square$  Burial 2  $\boxtimes$  Cremation 3  $\square$  Removal from State 2010 Clinton, Maryland Crematory Lee 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22 Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part ). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** un Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 W Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 Julyo 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ျှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending work 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of cortifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Univers.4 BLVD Eur MD (Month, Day, Year) C 1 0 2010 DEC 1 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Physician/ December 6,2010 545 M Cromwell Boone Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** icomico Lisbury Rehabilitation a Nursing Ctr lisburg If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Funeral Aug. I. 1913 Days 1 ₺ M 2 □ F North Carolina 97 237-60-8648 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 1 Yes 2 XNo Salisbury MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō r items 23a or ner must be n USA Funeral 21801 4312 Smith Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. . Was Decedent Ever in U.S. 11 Marital Status is marked other than "natural", or ite aumatic event, the Medical Examiner Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+ Elementary/Seconday (0-12) Farming Laborer 5th Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ပ Zomacky Unknown Willie Boone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 300, 12th St., Apt.303 - Delmar, DE 19940 L.B. Boone/ Nephew mportant; If item 27 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Springhill Memory Gardens 12/11/2010 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 21. Si mature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 121-Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 3 10 3 Probably 4 Unknown 1 Tyes Completed been si 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? cate has page 2 s 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 1 Yes 2 40 ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: ☐-Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical 1 Agertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29d. Date signed (Month, Day, Year) 2111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 lliam 31. Date filed (Month, Day, Year) 08 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $2^{6}10$ 10:15 PM Millard Ray Black Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Transitions Healthcare & Rehab Sykesville Carroll If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Months Hours 1 XM 2 □ F 7/03/1925 85 219-10-5950 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No Sykesville Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7309 Second Avenue 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 2 1 Never Married 2 Married 1943 Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify "natural", 3 Widowed 4 □ Divorced 1946 White Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) event, the C&P Telephone Cable Splicer 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) .. Page 1 and 2 sho ld re filed tment of Health and Mental H-tant; If item 27 is r ar ed ot Clarence Black Thelma Moorehouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Burnsway Court, Baltimore, MD Kimberly Molesworth/daughter 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State Department of Important; If any injury or Carroll Cremation 12/06/2010 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel Signature of Funeral Service Licensee in live 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ementa Pnysician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner hes 810 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed for use as the burial-tran and that initiated events Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Vear Month the s 9 Unknown Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 10 2 1400 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Natural 5  $\square$  Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 0054218 WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Raman B. Kanena 379 Males Im Lune, west minesty MD 21159 3 TIVA 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death December 5, Physician/ 2010 4:25 РΜ Ann E. Bohn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Kline Hospice House Mount Airy Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Days Hours (Month, Day, New Jersey 1 M 2 X F **Director** 057-20-4634 1927 83 May Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 1021 Lindfield Drive United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: "natural", 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done ( life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Claims Representative Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Julius Bosnyak Anna Gyuran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 12 Foxwood Court, Germantown, Maryland 20876 Barbara A. Harris (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan
Crematory December 11 1 Burial 2 Kermation 3 Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2010 . Signature of Funda Salvice Licens 22. Name and Address of Facility DeVol Funeral Home, M00689 10 East Deer Park Drive, Gaithersburg, MD 20877 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Ovarian Cancer disease or condition ) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading characteristic cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Sue to for es e consecuence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death s been signed by the same should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy page 2 performe 2 No 2 No 1 Yes Yes 25. Was case referred to edical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: neral Director: After filled in by the funera 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the I within 2. 29b. Signature and title of certifier 20 D60812 and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

DEC 09

32. Registrar's Signature

Robert/Lawrence Giuntoli, II, M.D. 600 N. Wolfe Street, #281, Baltimore, MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1822 Lucille Euranie Bennett 2010 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthdav) **Funeral** Guyana 1 □ M 2 🕱 F Months Hours Min. 09/11/1923 Yrs. Director 212-11-8471 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits filed within 72 hours after death with the Maryland ä 10a. State 10b. County 10c. City, Town or Location Director traumatic event, the Medical Examiner must be notified 1 🗌 Yes 2 🗓 No Silver Spring Maryland Montgomery ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 20904 13006 Tamarack Road items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 'natural", or 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Food Caterer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mabel Kathleen Payne Alfred Augustus Bone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 9200 Edwards Way, #205, Hyattsville, MD 20783 27 Lyndon A. LaBennett - Son Department of Health Important: If item 27 any injury or other the 20b. Place of Disposition (Name of cometery, crematory or other place)
Baltimore Czematory
at Loudon Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 12/08/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee reMay 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Weeks Immediate Cause (Final disease or condition Physician/ Aspiration Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Years End-Stage Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Seizure Disorder, Respiration Failure due to Pneumonia Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Required Mechanical Ventilation 24a Was an cate has l autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ၉ 1 

✓ Inpatient 2 

ER/Outpatient 3 

DOA To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 0 Barbara Suparich RSM, MD D 0065485 12-01-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich, RSM, MD, 1500 Forest Glen Road, Silver Spring, Maryland 20910

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

GEC

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Box (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carmen Alicia Barrientos December 2010 3:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours pr. 28 1 M 2 F 80 1930 El Salvador **Director** None Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgonery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 806 Dryden Street 20901 El Salvador 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 ★ Yes 2 No Specify:E1 If Yes, Give 3 🕅 Widowed 4 🗌 Divorced Specify: Completed White Year or Dates Salvador Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Automobile Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Rafaela Naves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin Armando Barrientos / Son 806 Dryden Street, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. Date cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 2010 Signature of Funeral Service Licensee Name and Address of Eacility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Pancreatic Cancer Medical Due to (or as a consequence of) Examiner Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is interested events and interested events.) by the attending physician and ached for use as the burial-tra sit Due to (or as a consequence or). Hospital or Attending Physician: The law requires that the death certificate be executed Failure To Thrive that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 2 x No 1 ☐ Yes 2 i 9 ☐ Unknowr 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Obstructive Jaundice 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has I autopsy page 2 Yes 2X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Be Hospital: Other: ပ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending Accident Investigation Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D60826 Dec. 5, 2010

State Registrar

2

31. Date filed (Month, Day, Year)

DEC 0 8 2010

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Gler Road, Silver Spring, MD 20910

Amend Item 1 per FH evidence G911 1/31/11 dk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-09379 John Bartrop Sackey

State of Maryland / Department of Health and Mental Hygiene

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		- For State egistrar	_	Certif	icate of	Death			eg. No.			
Physicia Medical Examin	Physician/ cal Examiner  1. Decedent's Name (First, Middle,Last)  Jon Bartrop Sacked  4a. Facility Name (if not institution, give street and number)						al anti-ref Doot	2. Date of Dea Month Decembe	3. Time of Death 1231 hrs			
- Land		Montgomery General	Hospital			Olney  If Under 1 Yea	r Location of Deat	Montgomery				
Funeral Director		5. Social Security Number  291-94-2353	6. Sex  1 X M 2 F	7. Age (In yrs. last I	Yrs.	_	7/1959	9. Birthplace (State or Fore Country) Ghana				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 injury or other traumatic event, the Medical Examiner must be no	lo Be Completed by Funeral Director	8612 Delctu  1. Marital Status  1 Never Married 2 X Ma  3 Widowed 4 Dive  15. Decedent's Education (Spece Elementary/Secondary (0-12)  7. Father's Name (First, Middle,	12. Was Dece   Armed For     1	e completed) 16 4 or 5+)  op-Sacket  se 20b. Plac crem Gate  MO124	13. Was If Ye  1 1 2  a. Decedent during mo  Senio.  19b. Mailing  8612  e of Dispositionatory or other  22. Na  118	Montgomery Village  10f. Zip Code  10g. Citizen of What Country?  20886  Vas. A.  Nas Decedent of Hispanic Origin? (Specify Yes or Noty Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 X No specify:  Specify:  Specify:  Specify:  Specify:  Blace the American Individual Country of the Specify:  Spec						
Physician /Medical -:xaminer	Examiner	fallure. List only one cause of mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last	on each line.  a. Diatone to (or as a control of the control of th	petic Ket consequence of): consequence of):	oacido	osis		or respiratory arre	est, shock, or hea	Approximate Interv Between Onset an Death		
Records, P.O. Box 687  The law requires that the death certificate has been signed by the attending page 2 should be detached for use as the page 2 should be detached for use as a second of the detached for the second of th	Completed by Priysiciani,	WINPENDED  FEMALE: bb. Was decedent pregnant in the past 12 months?  Yes 2 No 9 Unknown the past 11. Other significant conditions	23c. If yes, or 1 Live bir 4 Pregna 9 Unknow	utcome of pregnand th nt at time of death wn	cy Feta	al death 3  er (Specify)  derlying cause	Ectopic pregni	23e. Did to 1 Yes 24a. Was a autop perfor 1 Yes	an 24b. W sy p med? de	delivery Day Year  Dute to the cause of death? Probably 4 Unknown Vere autopsy findings available from to completion of cause of eath? Yes 2 No		
Division of vapiral or Attending Physical or Attending Physical and the meral Directors. After the fulled in by the funeral	27. Manner of Death 1 Natural 28d. Date of Injury Month, Day, Year) 28d. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Japanese - Japanes								ng Home 5 Residence 6 Other:  28d Describe how injury occurred  28f. Location (Street and Number or Rural Route Nu or Town, State)			
D Sta		D. Name and address of person of Ana Rubio MD. Assi	stant Medical E		•	O.C.	M.E. ore, MD 2120	1	December 7	7, 2010		

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ID#1 per PHY State of Maryia 14/2010 AACO HEALIH DEPICMH Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Geraldine Blanche Crowe Day Month Physician/ 5:15PM rowe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Arundel** Anne\_ Arnold <u>Future Care Chesapeake</u> If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthdav) **Funeral** 1 □ M 2 🖺 F (Month, Day, Year) 10/15/1927 Months Days Hours 83 Director 217-28-8803 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2x No Crownsville MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21032 441 Mountain Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 🍇 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 🗶 No Specify: 3 Widowed XX Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Nursing Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Arella Lancaster Alfonso Crowe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mountain Rd. Crownsville. MD 21032 Joanne Sears Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State 12/9/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of FacilityHardesty Funeral Home, P.A. . Signature of Funeral Service Licenses Tatel Md 21401 Annapolis, Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final years Pnysician/ en 0 disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year for Day 5 Other (specify) Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached a 🗆 Unknown g Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes Completed 24b. Were autopsy findings available viere autopsy findings available prior to completion of cause of death? Covonary autopsy perform 1 🗌 Yes 2 🗌 No Yes 2 26. Place of Death (Check only one) 25. Was case referred to medica Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖳 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 욘 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural work? injury 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 50725 mb s Hwy M. Wersille MD 21108 completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Janet Hart Callaway December 9, 2010 Lee 8:52 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 32131 Huntley Circle Salisbury Wicomico 5. Social Security Number Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) 10/04/1938 1 □ M 2**X** F Months Days Min. 162-32-3301 **Director** 72 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at orge. 10c. City, Town or Location 10d. Inside City Limits Director Maryland Salisbury 1 Yes 2 X No Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32131 Huntley Circle 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🕱 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Wildowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) teacher/librarian education 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Harry Nord Hart Virginia Edna Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Callaway/daughter 32131 Huntley Circle, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Wicomico Memorial Park 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/14/2010 Salisbury, MD 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ ) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): that the death certificate be executed ending physician and use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy sate has been signed by the atte page 2 should be detached for i in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 🔀 No Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 🔀 No Other: ပ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi-29c. License number D24986 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -60 Riverside Dr. BIOI Salisbury Md.

DHMH 17 Rev 7/2009

State

Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

32. gegistrar's Signature

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 2356 P M Medical Michael Lee Cooper 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wicomico Regional Medical 9. Birthplace (State or Foreign Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 🗆 F Days Months Min (Month, Day, Year) Country Director 21-48-5800 Usual Residence of Decedent 23a or 28a-f show 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21849 7476 Rachell Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes No If Yes, Give Black White etc. 1 X Never Married 2 ☐ Married ۵ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: SpecifWhite Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Store Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mildred Ann Littleton James Leon Cooper, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 31801 Mary Farm Rd, Selbyville, DE 19975 Mildred Cooper/Mother injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory, 2/10/2010 Dover, DE 22. Name and Address of Facility 17 W. Isabella St. Bennie Smith any Funeral Home Salisbury or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory at ist only one eduse on each line. 23a. Part 1. Enter the disease shock, or heart failure Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Multiple Organ Failure disease or condition Medical resulting in death) Examiner Caposis Sarcoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine sician and burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be uman im unodeficiera virus use as the IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy 23d. Date of delivery Box ( Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months? Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 🗌 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; I of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Division Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Peters-Harris, mo D70961 12/02/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Carroll St. Salisbury MD 2 1801 Teters MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amended #10c & 17 per FH, RG ECHD 12/17/10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11,201° 2:15 P. December ANTHONY CACCESE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Citizens Care & Rehab Center Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 X M 2 □ F Months Hours July 25, 1925 Pennsylvania 85 **Director** 193-14-3272 Usual Residence of Decedent 28a-f shov with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Hazleton PA Luzerne Hazelton 1 X Yes 2 No 5 10e. Street and Numbe 10f. Zip Còde 10g. Citizen of What Country? 23a Funeral USA 103 West Diamond Avenue 18201 death "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. ģ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 □ Divorced If Yes, Give Specify: Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Salesman 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Manufacture Rep. Be permit. Page 1 and 2 should be filed Department of Health and Mental Hyy Important: If item 27 is marked oth-any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Rose Paris Cerald Gerard ည Caccese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Frederick, Md 21702 Old Coach Court, Anthony Caccese, II/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Mathematical 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/18/2010 Drums, PA Calvary Cemetery 22. Name and Address of Facility Stauffer Funeral Home, PA Signature of Funeral Service License salem 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on: Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the detached 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed this certificate Yes 1 Yes 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed To the within 2 only one 29b. Signature and tit f certifie 29c. License number 29d. Date signed Month, Day, a

DHMH 17 Rev 7/2009

State

Registrar

Beka

**3**00 W. 9th Street,

32. Registrar's Signature

- Copiestand

Frederick, MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Dr. Robert Kaufmann

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

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	Physicia	ın/	1. Decedent's Nam								2. Date of De	eath	)av Ve	ar	3. Time	of Death	
,	Medic	al	Bern 4a. Facility Name (if		give street and number	_	Copeland December							7 2010 5:20 PM  4c. County of Death			
	LXaiiiii	er	Sunrise	of Anna	apolis Assi		Living		polis			4		Arunde1			
	Funeral Director		5. <b>238</b> Security N 233-44-8		6. Sex 7. 1   ↑ M 2 ☐ F	Age (In yrs.	last birthday) Yrs.	If Under 1 You Months Da	ear If Ui	inder 24 Hrs. urs Min.	8. Date of Bi	rth av Year)	9. N.	Birthplace (State or Foreign Country) Orth Carolina			
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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	734 Bay	front	Avenue	ent Ever in II	S 12 V	2071		c Origin? (Spe	cify Vec or No		USA		- !!:		
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Maryland 21215-0036	ours at atural" cal Exe	Completed	3 💢 Widowed		If Yes, Give Year or Date	s.		Yes 2 X		ecity:		T	Specify:	Втаск			
215	in 72 h e. nan "na	dwg	(Spe	cify only highe	st grade completed)  College (1-4	or 5+)	(Give k		ne durina	most of worki	ng	16b.	Kind of Busin	Kind of Business Industry			
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re, N	and 2 Health tem 27		20a. Method of Disp	osition	sley Copela	20b.	Place of Dispos	sition (Name of		ox 1280	), Palo				94302 or Town, State		
mo	Page 1 nent of ant: If i		1 ☐ Burial 2. 4 ☐ Donation		3 ☐ Removal from St pecify)	ate	cemetery, crem tropoli	atory or other	place)				exandr				
Baltimore,	permit. Departr Importa any inju		21. Signature of Fu	peral Service L	icensee		22	Name and Ac	ldress of F	acility Rau	ısch Fu	nera	al Home	e, P	.A.		
	20210		23a. Part 1. Enter t	the disease, or	complications that cau	sed the dea				mony La	· ·		s, MD	207	36 Approxima	ate	
1	Physician/	Н	shock, or hea Immediate Cause ( disease or condition	Final	nly one cause on each	line.	1.2001	Arter	v d	(Ceaho					Interval Be Onset and	etween	
	Medical Examiner		resulting in death)		a. Due to (or	as a conseq	uence of	// / / / / /	/ 4	000016							
	executed ian and irial-transit	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											+			
		xami	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in the past 12 months?  1														
_	be exe sician a burial	<u></u>															
Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death certificate be 24 hours after death. After this certificate has been signed by the attending physicated filled in by the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but after the funeral director.	Medi													_		
9 XC	ath cert attendir for use	ian/l	23b. Was decedent in the past 12 in	months?	23c. If yes, outco 1 ☐ Live Bir 4 ☐ Pregna	th 2 🗌 Fet	al death 3	Ectopic pregi					23d. Date o Month		y Day	Year	
). Be	the dea	hysid	1 Yes 2 9 Unknown	∐ No	9 Unknov		death 5 L	Other (specify	/)								
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ords	require been s should	leted	741	)	40	1000					1 □		2 No 3 [			J Unknown s available	
Division of Vital Records,	sician: The law is certificate has birector, page 2 s	Completed									auto perf		prior deat	r to com	pletion of		
tal	ician: T	Be	25. Was case referre examiner?	/	Hospital:					Death (Check		2 🗷	NO TE	103 2	NO		
of V	Attending Physician: er death. ector: After this certific by the funeral director,	e: To	27. Manner of Deati		1 L Ing 28a. Date of	injury	ER/Outpatien 28b. Time of	t 3 □ DOA 28c. I	njury at	☐ Nursing Ho	me 5 Res			Specify)	Assi Livi		
ion	tending leath. or: Afte the fun	Certificate:	1 M Natural 2  Accident 3  Suicide	5 ☐ Pendin Investiç 6 ☐ Could	ation	Day, Year)	injury		vork?	2 🗆 No							
ivis	I or Atten after deat Director:		4 Homicide	determ	ined 28e. Place of	Injury - At he etc. (Specif	ome, farm, stre	et, factory, offi	ce		28f. Location ( City or To			r Rural I	Route Nun	nber,	
	To the Hospital or / within 24 hours after To the Funeral Dire completed filled in b	Medical	29a. Certifier 1 (Check 2	Certifying  Medical E	Physician: To the bes	t of my know	rledge, death o	ccured at the t	ime, date	and place, an	d due to the ca	ause(s) a	and manner as	s stated		anner etated	
	o the Hithin 24 orthe Formplet	Me		☐ Certifying	Nurse Practioner: To			eath occurred		, date and plac		ne cause	e(s) and manne	er as sta	ted.	laillei stateu	
	F 3 F 3		29b. Signature and title of certifier  29c. License number  29d. Date signed (Mo.)  1219														
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	Registra			UEC	-9 2010	Denew	a 1.	back									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year М ANDERSON CRADDICK 12/6/2010 0049 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth (Month, Day, Yea 7/2/1946 Min. 1 🕱 M 2 □ F **Director** Yrs 258**–**66–7488 64 Athens Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5707 Cloverleaf Ave. 20735 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 🙀 Married δ Baltimore, Maryland 21215-0036 1 Yes XXXNo Specify: Specify. 3 Widowed 4 Divorced Completed Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Installer Lucent Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willie Craddick Nancy Bullard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Craddick / Wife Cloverleaf Ave. Clinton, Maryland 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 12/16/10 Cheltenham, Maryland . Signature of Funeral Service Libensee 22. Name and Address of FacilityPope Funeral Homes, P. A. MOLORS 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ITY hosi Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Exami that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 nding puse as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death g Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hepatorenal disease Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Liver Cancer 24a. Was an autopsy page To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director, After this certificate h completed filled in by the funeral director, page performed? Yes 2 1 Tes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No ည 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division 2 No 2 ☐ Accident Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0052999 allundy MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

4 2010

CLM

10403 Hospital Dr. G-06 CLINTON MD 20731

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Randolph Fredrick Coston 2:12 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death isburg Wicomico bspice at Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth July 5, 1948 1 🛛 M 2 🗆 F Months Hours Min. Maryland 218-48-7269 62 Yrs Director Usual Residence of Decedent or 28a-f shoven 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Pocomoke City 1 Yes 2 XNo Worcester MD ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral Bonneville Ave. P.O. Box 533 21851 USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural" 3 Widowed 4 Divorced Specify: Black Completed of Health and Mental Hygiene.
Item 27 is marked other than "natul other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager 12th Food Lion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve မ Elton Coston, Sr. Wilsie Milbourne Randelph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrtle M. Martin/ Sister 7015 Scotland Road - Snow Hill, Maryland 21863 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Snow Hill, MD 12/11/2010 4 Donation 5 Other (Specify) Mt. Wesley UMC Cemetery 21. Signuture of Funeral Service Licenses 22. Name and Address of Facility Salisbury, MD 1213 Jersey Road 21801 Jolley Memorial Chapel -23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ CARCINOMA MALIG MAN LUNC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has performed death? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျ 1 Tes PICR 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending ☐ Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie

State

Registrar

17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

**DEC 0 8** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Allan Crouch 11:40AM Walter December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 5694 Liberty Street Rock Hall Ken.t Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 07/25/1929 Delaware 1 XM 2 □ F Months Days Hours Director 213-22-7695 81 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland al Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5694 Liberty Street 21661 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. o. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 XMarried 1X Yes If Yes, Give 2 No Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Year or Dates White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Navy Engineman Mechanics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Walter Pierce Crouch Elsie Bryden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Jane Crouch - Wife 5694 Liberty Street Rock Hall, Maryland 21661 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Weslev Chapel 12/09/2010 Rock Hall, Maryland S nat re of Funeral Service Lie <sup>22. Name and Address of Facility</sup>
Fellows, Helfenbein & Newnam Funeral 130 Speer Road Chestertown, Maryland Pan 1. Enter the disease, or complica shock, or heart failure. List only one of ions that caused the ceath. Do not enter the mode of duing, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of, if any, leading to immediate cause. Elier Underlying Cause (Disease or linjury that initiated events and tran Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death the detached g 🔲 Unknown Division of Vital Records, P.O. ģ signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? و ک 4 Unknown 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform this certificate 2 🗌 No 1 Yes ☐ Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify funeral 28a. Date of injury (Month, Day, Year) Manner of Dea 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending death. Accident Investigation M within 24 hours after death

To the Funeral Director: / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b, Signature and title of certifie 29d. Date signed (Month, Day, Year) 0

Registrar
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30. Name and address of person who comple

d cause of death (Item 23a) (Type, Print)

32 Regis

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 11:45AM Phillip Lee Clough Medical Novembei 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Queen Anne's 550 Bolton Woods Road Sudlersville If Under 1 Year I If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days Hours Maryland 08/28/1964 **Director** 46 216-74-1440 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Sudlersville MD Queen Anne's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21668 550 Bolton Woods Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", Specify: 3 Widowed 4X Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Machinery Small Engine Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alman Clough Peggy Ann Clark and 2 should be Health and Meter 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Clough - Brother permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other t Cypress Street Millington, Maryland 21651 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20b. Place of Disposition (Varine of cemetery, crematory or other place)

Chesapeake Cremation 12/2/2010 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chester, Maryland 21. Signature of Funeral Service Licenses Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 Cypress Street, Millington, Maryland 21651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earthline. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Bisease sician and burial-transit ronic Cause (Disease or iinjury that initiated events resulting in death) Last IVS Due to (or as a consequence of) signed by the attending physician d be detached for use as the burial Physician/Medical requires that the death certificate be Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sastric Ucer Records, 3 Probably 4 ☐ Unknown 1 Yes 2 No peen memia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 🗌 Yes 읻 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practiceer: To the best of my knowledge, death occurred at the time date and place and due to the cause(s) and manner stated. only one 29b. Signature and title or certifier 29d. Date signed (Month, Day, Year) NP080263 30. Name and address of person W 115 MID 21620 31. Date filed (Morti Di) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Franya Lynn Cook December 2010 3:50 P M Medical a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
May 29,1980 7. Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Days Hours Virginia Yrs Director 212-19-5861 30 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Crofton ŏ 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 1611 Park Ridge Circle 21114 United States death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Biller Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည Franklin Jeter Marion Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 1611 Park Ridge Circle, Crofton, Maryland 21114 or other Chaun Cook/Husband Itimore, .c. Page 1 ≥ Sartment o' 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State pernit. Page 1 a Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Domation 5 Other (Specify) Mount Morris Cemetery 12/8/2010 Hume, Virginia 21. Signature of Figheral Service ice 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Sreast disease or condition resulting in death) Cancel Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burial-t physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending r SB IF FEMALE: ase s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown ed by t detach signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated by page 2 should b 2 No 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only o 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) 065272 12/1/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nokury Suit 210 Annigoly MO 21401 2003 ason aksey 31. Date filed (Month, Day, Year)

OEC 0 9 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 0 1 0° Physician/ Dec. 4 . 2:36 pm Yu-Yuan Lai Chang Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 28,1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Country) Taiwan Min. Hours 1 ☐ M 2**X**☐ F Aug. Director 91 220-06-8968 Usual Residence of Decedent show 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director MD Olney Montgomery 1 Tyes 2 KNO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 20832 3541 Bantry Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Specify: Asian 21215-0036 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 6 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland ഉ Ougei Huang Ler Lai I and 2 should b f Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) - Daughte  $t_{19b.\ Mailing}$  Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3518 Everton Street, Silver Spring, MD 20906 Jannie C. Schwartz Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Page 1 cemetery, crematory or other place Gate of Heaven 1 🔀 Surial 2 □ Cremation 3 □ Removal from State Dec 14 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) emetery 21. Signature of Funeral Service Licensee 27 Name and Adgress of Facility ollins Fun 50C University Blvd. W.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or book or book of bliggs. 27 Pagardagessyf Facilicollins Funeral Home W.. Silver Spring, Md Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) nours Medical Due to (or as a consequence Examiner lours Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury 10Urs attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death detached 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 2 No prior to completion of cause of death? has 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 28b. Time of 27. Manner of Death 28a, Date of injury 28d. Describe how injury occurred 28c. Injury at Certificate: (Month, Day, Year) 1 Natural 5 Pending work? Investigation
6 Could not be death. Accident 24 hours after deat Funeral Director; 3 Sulcide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X Certifying Physicia or the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Plactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and tiple of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD 30. Name and address of person w o complet d cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Royconle, Maryland Panitch, 31. Date filed (Month, Day, Year) State 1 0 2010 DEC Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ZOIC 33 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2 Himore Medical ente Himore Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 W Months Days Hours Min. (Month, Day, Year, COLORADO Director 62 231-68-5445 1<del>0/16/1948</del> Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c, City, Town or Location the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Directo BERKELEY MARTINSBURG W۷ 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1466 MYERS BRIDGE ROAD 25404 USA should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ⋛ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🙀 No 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME **HOMEMAKER** permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RALPH KLEINSCHMIDT BERNICE BEERY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 1728, MARTINSBURG, WV 25402 DONALD COGHLAN/SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) DEC. 18, SMITHSBURG CREMATORY SMITHSBURG, MD 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821 MARTINSBURG, WV 25402 KING ST 327 W 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Knaus Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Ducito (or as a consequence of, attending physician and for use as the bunal-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death MA NIA 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Tes Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Hospital 2 **V**No NIA မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at WA Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined PIA Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year, and dress of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year :48 pm Dickerson Thomas December 04 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Johns Hopk 5. Social Security Number Bayview Medical Center Baltimore
If Under 1 Year | If Under 24 Hrs. Hopkins 8. Date of Birth May 9, 1942 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 € M 2 □ F Months Days Hours 68 212-40-8448 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 Yes 2 No VA Horntown Accomack 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23395 34008 Horntown Road USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No African-1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Wicomico County Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Bus Contractor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marion Dorman Mervin Dickerson, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois H. Dickerson/wife 34008 Horntown Rd., Horntown, VA 23395 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Green Acres Mem Park | 12/11/2010 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): hours psis 24 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No

**Physician** Examiner

be executed

Box 68760,

P.0.

**Physician** 

Examiner

**Funeral** 

Director

item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

72 hours after

and 2 should be fillealth and Mental Pm 27 Is marked otl

permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other tra

Baltimore, Maryland 21215-0036

/Medical

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Funeral

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Completed

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Examiner as the burial-transit attending physician Physician/Medical for use a ed by the a detached f been signed be should be deta þ Completed funeral director, Be ၀ this Certification:

27. Manner of Death

2 Accident

3 ☐ Suicide

one)

4 Homicide

5 Pending

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Division or Vital Records, Hospital or Attending P 4 hours after death.

Tuneral Director: After t the filled in by To the Hospital c within 24 hours af To the Funeral D

State

Medical

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

December 04 2010

29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD Eastern Ave. Baltimore MD trogale ristina 4940 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

0-09728 ara Leigh Dewit	t	<b>Please Typ</b> St	oe or Print in ate of Maryla	Black In	idelible artment (	<b>Ink. Er</b> of Healt	nsure h and	All Co Menta	<b>pies</b> Il Hygi	<b>Are Leg</b> iene	ible.		) 4113			
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Physicia Medical Examir	n/	Decedent's Name (First, Middle	e,Last) Kã	ra Lei	gh DeW	itt			- 0	Date of Death Month December	Day 17, 2010 Year		3. Time of Death 1049 hrs			
		4a. Facility Name (if not institution 11907 Rainbow Avenue)		nber)		4b. City, To Smith		ocation of E	Death	4c. County of Death Washington						
Funeral		Social Security Number		7. Age (In yrs. I	ast birthday)	If Unde	nder 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or									
Director		213-13-5762	1M 2XF	24	Y	rs. Months	Days	Hours	Min.	Sept. 2	20,1986	Foreigi Cou	ntry) Maryland			
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e Mary or 28a-	Director	10e. Street and Number  11907 Rainbo	ow Avenue			10f. Zip		783		10	g. Citizen of Wh $U.S$		try /			
death with the Maryland ritems 23a or 28a-f sho nust be notified at once.	— L	11. Marital Status  1 Never Married 2 M	12. Was Dece	rces?		Vas Deceder Yes, specify				fy Yes or No- an, etc.)	14. Race White		inplace (State or in untry) Maryland  10d. Inside City Limits 1 Yes 2 No  ntry?  can Indian, Black,  nite Industry  Washington  Ty  Zip Code) 2 1783  Town, State 3, Maryland  Home 2 1783  Approximate Interval Between Onset and Death  Death  Your Year  the cause of death?  bably 4 Vunknown  utopsy findings available completion of cause of ess 2 No  r Scene			
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5-0036 lied within 72 hours after Hygiene. I other than "natural", the Medical Examiner	17. Father's Name (First, ivilooie,	<u> </u>		1		,		laioen Surname) Bracker								
2121 Muld be fi Mental marked c event,	Nogaria Douglas E. DeWitt							_			ber, City or Town		Zip Code)			
O # 2	]٤	Donna J. Valer		ther)	1190	907 Rainbow Ave. Smithsburg, Mary							cyland 21783			
		20a. Method of Disposition  1 XBurial 2 Cremation	n 3 Removal fro	m State	Place of Disp crematory or	other place)			Dec	<sup>ate</sup> ember	20c. Location -	-				
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Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	complications that ca on each line. $Pu1$	used the death <b>monary</b>	Do not ente	r the mode o	dying, s	Due	diac or re To D	spiratory arre	st, shock, or hea Lin	art	Between Onset and			
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760, cate be physical	Med	IF FEMALE:	23c. If yes, o	utcome of preg	nancy						23d. Date of					
Box 68760, e death certificate be ex the attending physician ed for use as the burial	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	4 Pregna	rth ant at time of de		Fetal death Other (Spec	3 <u>L</u> cify)	_Ectopic p	regnancy	•	Month	C	ay Year			
BO) he death the att	hysi	1 Yes 2 No 9 ✓ Uni Part II. Other significant condit	3 Officio		regulting in the	o underlying	cause di	ven in Part		23e Did to	hacco use contri	bute to	the cause of death?			
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230 Date of Joint 28h Tim							28c. Injury	at Work?	28		now injury occurr					
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying P	hysician: To the best	of my knowled	dge, death occ	curred at the	time, dat	te and place	e, and du	e to the cause	e(s) and manner	as state	ed (a)			
To the within To the comple	Medical	one) 2 Medical Example 29b. Signature and title of certific	aminer: On the basis of and manner st		and/or investi		c. License		ared at th	e une, date a	and place, and d					
		70.01	1116	e TO		\	O.C.N		OCME			ember 18, 2010				
		30. Name and address of persor Theodore M. King, Jr.		e of death (Ifer nt Medical		111 Pa	enn Str	eet Balti	imore	MD 21201	<u> </u>					
St	ate	31. Date filed (Month, Day, Year)	/ 32. Re	sisteria Cianat	1150		0(1)									
Regist		DEC 2.9 2010	Acien	D. 1	barker											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12/6/2010 Physician/ WILLIAM H. DIAMOND 1:04 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST. MARY'S COUNTY HOSPITAL LEONARDTOWN ST. MARY'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Days Min. 1 XM 2 | F Hours (Month, Day, Year) 9/20/1926 **Director** 422-26-1726 84 Piedmont Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | St. Mary's Bushwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 36899 Skyview Drive 20618 USA death \ 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or þ 1 Never Married 2 Married 72 hours after XYes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 Divorced Specify: Completed Year or Dates Black traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumation.  ${ t Plumber}$ U.S. NAVY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Hollis Diamond Daisy Southerland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary F. Powell / Companion 36899 Skyview Drive Bushwood, Maryland 20618 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 12/16/2010 | Suitland, Maryland Sign Jure of Funeral Service Livensee 22. Name and Address of Facility Pope Funeral Homes, P.A. MOLOSS 5538 Marlboro Pike Forestville, Maryland 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if a y leading to him ediate cause. Enter Underlying Cause (Disease or iinjury Examiner or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): the burial physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Dav Year 1 Yes 2 L 9 Unknown been signed by the a should be detached i 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of this certificate has page 2 autopsy death? perform 2 🗌 No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes ဂ္ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer 5  $\square$  Pending Natural 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0062893 MA

Registrar
DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		Registrar  1. Decedent's Name	ie (First, Middle	e, Last)				Crance	ate of L	, catri		2. Date of De				3. Tin	ne of Death	
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daryla 8a-f s tified	Director	MD	Montgo	mery			Burtor	svil	1e							1 🔀	Yes 2 □ No	
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th with ms 23 must	Funeral	4014 Wood	d Swall						20866					iopi				
or iter	by Fu	<ul><li>11. Marital Status</li><li>1 Never Marr</li></ul>	ried 2 🗆 Mar		Was Deced Armed For 1 ☐ Yes		J.S. 13	3. Was De If Yes, s	cedent of Hi pecify Cuba	spanic Or n, Mexica	rigin? (Spe in, Puerto	ecify Yes or No- Rican, etc.)			ice - Ame ack, White	erican India: e, etc.	n,	
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Page nent o ant: If Iry or		1 🔀 Burial 2 4 □ Donation	☐ Cremation 5 ☐ Other (\$	3 □ Rem Specify)	oval from	State Far	cemetery, c nily C	-			12-11	-2010	Et	hiop	ia			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service 1					22. Name	and Addres	s of Facil	ity <b>W .</b> H	. Bacon	Fu	nera	1 Ho		nc.	
<u></u>		23a. Part 1. Enter t	ual	7 0	71	eos 8								n, D	C 20			
N			rt failure. List o	only one car	use on eac	ch line.				, such as	cardiac c	or respiratory ar	rest,			Interval	Between	
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tificati ing ph	Physician/Medical	IF FEMALE:																
ath cer attendi for use	cian/	23b. Was decedent in the past 12 t 1 Pres 2		1	1 🔲 Live E	ome of pregr Birth 2  Fe ant at time or	tal death	Ectop	ic pregnanc	у					ate of de Ionth		Year	
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that tined by	by P	Part II. Other signif	ficant condition	ns contrib	uting to de	eath but not re	esulting in the	e underlyir	ng cause giv	en in Part	: I,	23e. Did t	obacco	use cor	ntribute to	the cause	of death?	
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ospita hours uneral	Medical	29a. Certifier 1	Certifying	Physician	: To the be	est of my know	wledge, deat	h occured	at the time,	date and	place, an	d due to the ca	ıu <b>se</b> (s)	and man	ner as sta	ated.		
the Hin 24 hin 24 the Fu		only one) 3	Certifying	Nurse Pra				e, death oc	curred at the	time, dat		e, and due to th	e cause	e(s) and n	nanner as	stated.	d manner stated.	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but		29b. Signature and				OCAR			29c. License		10-	. 1				h, Day, Year		
-		30. Name and addre	ess of person	who comple	eted cause	of death (Ite	m 23a) (Tvne	, Print)	D 006	55 9	82		/ /	-10	11/	2010	7	
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Stat	e	31. Date filed (Month	h, Day, Year)	กาก	32. Re	gistrar's Sign	ature	-	ŕ									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death RegistraMEND#1perMD, 12/9/10, BMW, McCo 1. Decedent's Name (First, Middle, Last)Fior 2. Date of Death Daliza Santana De De Pool 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number)
1530 7th Street 4b. City, Town, or Location of Death Glenarden 4c. Prince George's **Examiner** 9. Birthplace (State or Foreign Country) Report Dominican 5. Social Security Number 7. Age (In yrs. last birthday) 86 vrs If Under 1 Year 8. Date of Birth 6. Sex **Funeral** Min. 1 🗆 M 2 🔀 F Months Days Hours 7/2371924 none Director Usual Residence of Deceden or 28a-f shov 10d. Inside City Limits 10a. State 10b. County . Page 1 and 2 should be filed within 72 hours after death with the Maryland irnent of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location S Glenarden or items 23a or 28a-f sho miner must be notified at Director Prince George' MD 1 Tes 2X No 10f. Zip Code 20706 10e. Street and Number 10g. Citizen of What Country? Rep.of Dominican 1530 7th Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rep. of 14. Race - American Indian, Was Decedent Ever in U.S. Examiner **Baltimore, Maryland 21215-0036**permit. Page 1 and 2 should be filed within 72 hours after dee Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine once. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 🛚 Yes 2 □ No Specify: Dominican If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working fe. DO NOT use retireuj Homemaker Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beatriz Vincent Pion Luis Maria Santana Castillo မ <sup>19a.</sup> Informant's Name/Relationship *(Type, Print)* Mildred De Pool/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1530 7th Street Glenarden, Maryland 20706 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crem. 12/4/2010 Beltsville, Md. 4 Donation Б ☐ Other (Specify) / P.Mantalopadoles Richaldi Funeral Service, P.A. 21. Signature Columbia Blvd.Silver Spring, Md20910 9241 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ₽hysician/ disease or condition resulting in death) m Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a ending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ 2 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical retifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c, License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, 2. Registrar's Sign State

Registrar

09

DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Allen 2010 515 PM 1 2 wrence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washing Halthcare of Hul Hagerstown Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/27/1932 Age (In yrs. last birthday, Birthglace (State or Foreign Country) **Funeral** 1XM 2□ F MD Director 78 220-28-6696 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a State 10b. County 1XYes 2 No Director Frederick Winchester VA 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ortant: If item 27 Is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be I USA 22602 126 Country Park Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other transmission. Elementary/Secondary (0-12) College (1-4or 5+) Construction 5th Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Thompson Lawrence Duffin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 Country Park Drive, Winchester, VA 22602 Glenda L. Anderson/wife 20a. Method of Disposition sposition (Name of crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 □ Removal from Sta Ardent/Cremation Svc 12/08/10 Hanover, MD 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility 21. Signature of Feneral Service Licens Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications, or heart failure. List only of to not enter the mode of dying, such as cardiac or respiratory arrest, no that caused the deal Immediate Cause (Final disease or condition resulting in death) **Physician** heimer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi be exec Due to (or as a consequence of) Box 68760. physician Physician/Medical the as the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 nellitu 4 Únknown 1 Tes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2: autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification; To the Hospital or Attending I within 24 hours af er death.

To the Funeral Director After 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled i by 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 201 30. Name and address of person who comple he Hagerstown MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December 19, 2010 James Harrison Donald 5:20M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Egle Nursing and Rehabilitation Center Lonaconing Allegany Social Security Number 8. Date of Birth (Month, Day, Year) February 26, 1931 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** Days Hours **Director** 215-36-9907 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 No Allegany Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Park Street 21539 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 - Widowed 4 - Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Truck Driver Sanitation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Harrison Donald Mary Estella Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Donald - Wife 3 Park Street, Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date December 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. View Cemetery 22, 2010 Moscow Mills, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate ē Due to (or as a consinguind) of cause. Enter Underlying Cause (Disease or linjury that initiated events Examir I or Attending Physician: The law requires that the death certificate be executed after death. attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day n signed by the a lid be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Director: After this certificate 1 ☐ Yes 2 🛛 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Tyes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural injury 5 Pending Accident
Suicide Investigation М 1 Tes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bisho/ Jakh Rod Cumberland, Mary Ind

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar's Signature

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Wesley Edwards /5010 <u>16:4</u>5 P<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clinton Prince George's Southern Maryland Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 578-76-3110 55 **Director** 0473071955 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's 1 Yes 2 No Fort Washington 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 20744 6810 Southfield Rd⋅ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Correctional Officer Dept. of Human Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wesley Edwards Joyce Marie Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Edwards / wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem. 12/16/2010 Cheltenham, MD Signat Funeral Si 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final INFARCTION MYOCARDIAL Ph sician/ ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequent of if any leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC OBSTRUCTIVE LUNE 1 Yes 2 No 3 Probably 4 Unknown Completed DISEASE KIDNEY CHRONIC 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has ral director, page 2 autopsy DIABLETES TYPE MEGLITUS 2 death? 1 ☐ Yes 2 ☐ No 1 Yes 2 🖵 25. Was case referred to dedical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>ء</u> 2 No Inpatient 2 ER/Outpatient 3 DOA funeral n 24 hours after geaus. he Funeral Director: After the releted filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Contifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064986 12/3/2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Date filed (Month State DEC 1 0 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Physician Medica Examine **Funeral** Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

•	For State Registrar		Cer	tificate of D	eath	nonan m	Reg. No.	2010	6 - 10 day	. 11	4	
,	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		/ Voor		3. Time of D	Death	
al	Nathelma Alic					12	02 <sup>Day</sup>	2010		21:45	М	
r	4a. Facility Name (if not institution, give str			4b. City, Town, or	County of Dea							
	Holy Cross Hospit  5. Social Security Number 6. Sex		et hirthday)	Silver	Spring If Under 24 Hrs.	8. Date of Bir		ntgome		- (Dt-t :	F t	
		M 2 🕱 F 91	Yrs.	Months Days	Hours Min.	(Month, Da	tn ly, <sup>Year)</sup> 18 19	)19	rthplac ountry)	DC State or i	Foreign	
ö	10a. State 10b. County	10c. City	, Town or Loc	cation					10d.	. Inside City	/ Limits	
ect	MD Montgome	ry   Sil	ver Sp	ring						1 Yes 2	2 🗆 No	
۵	10e. Street and Number 10f. Zip Code 10g. Citizen of What											
Funeral Director	11434 Lockwood Dr	ive		20904			USA					
Ē	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?		Vas Decedent of His Yes, specify Cubar	panic Origin? (Spe	ecify Yes or No-		14. Race - Am				
Completed by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		☐ Yes 2 🖾 No			3	,	lack, White, etc. <sub>fry:</sub> Black			
plet	15. Decedent's Educ (Specify only highest grade		tion uring most of work	ina	nd of Business	indus	try					
mo.		and most of work	n g	D- 1-	1 C-							
Be C	17. Father's Name (First, Middle, Last)	2 years	Super	visor	18. Mother's Nam			eral Go	ver	nment		
TO E	Edward Jackson	Sumame)										
	19a. Informant's Name/Relationship (Type	Town, State, Z	:- O/	(-)								
	Malvern F. Jackso			7 Interla						,	906	
	20a. Method of Disposition		ace of Dispos	sition (Name of natory or other place	!	Date		cation - City o				
	1 XBurial 2 Cremation 3 R 4 Donation 5 Other (Specify)	Lin	coln (	Cemetery	12/	10/2010						
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washignton, DC 20011											
	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death cause on each line.	. Do not ente	r the mode of dying	, such as cardiac	or respiratory ar	rest,		Ap	pproximate terval Betwe	een	
	Immediate Cause (Final disease or condition	Chronic Ob	struct	ive Pulmo	onary Dis	sease				nset and De		
	resulting in death)											
ııner	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque										
edical Examiner	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Pulmonary  Due to (or as a conseque		tension								
call												
	d.											
_	23b. Was decedent pregnant	Bc. If yes, outcome of pregnan		Ectopic pregnancy			2	23d. Date of de	elivery			
Pnysician/	in the past 12 months? 1  Yes 2 No	4 Pregnant at time of de						Month	Da	y Ye	ar	
۲ny	9 ☐ Unknown  Part II. Other significant conditions cont		Iting in the ur	ndorlyino oguso give	on in Bort I	00 0111					41.0	
Completed by	i ar ii. Other significant contituons cont	ributing to death but not resu	itang in the di	ndenying cause give	an in Fart I.			se contribute to				
etec												
m m						24a. Was auto	psv	24b. Were au prior to death?	compl	letion of cau	use of	
	25. Was case referred to medical			00.51			2 A No	1 ☐ Ye	s 24	No		
lo Be	evaminer?	ospital:		0.11	ce of Death (Chec							
	27. Manner of Death		28b. Time of	28c. Injury	4 Nursing Ho	ome 5 L. Residence 1 28d. Describe I			cify)			
Icat	1 X Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day, Year)	injury	M 1 🗆 Y	res 2 □ No		, ,					
Certificate;	3 Suicide 6 Could not be 4 Homicide Certained determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Fig. 1) City or Town, State)										т,	
Medical	(Check 2 \(\sumeq\) Medical Examine	ian: To the best of my knowle r: On the basis of examination Practioner: To the best of my	and/or investi	igation, in my opinior	n, death occurred a	t the time, date a	and place,	and due to the	cause(	s) and manr	ner stated.	
-	29b. Signature and title of certifier			29c. License				e signed (Mont			_	
	Man	~		200	66065		12	9-2	010	5		
	30. Name and address of person who con	mpleted cause of death (Item 2	23a) (Type, Pr	rint) FOREST	GLEN A	RD. Sic	VER 3	SPRING	M	D-20'	910	
	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		ALD!			-				,	

DHMH 17 Rev 7/2009

State Registra

10-09584 Michael Farrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month 0748 hrs **Medical Examiner** Michael Farrar December 13, 2010 Steven 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Poolesville Selden Island 5. Social Security Number If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 02/28/1966 459-31-3821 44 Country) Germany 1 XM 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 YNo Sterling Loudoun item 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 20 Fentonwood Drive 20165 USA 14. Race - American Indian, Black 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes If Yes. Give Yeer 3 Widowed 4 Divorced 1 Yes 2 No specify: Specify: White ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Engineer Computer of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William Farrar Ursula Himstedt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sterling, VA Wife Annelee Aveling-Farrar 20 Fentonwood Drive 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition timore, permit. Pages 1
Department of H
Important: If i or other 1 Burial 2 X Cremation 3 Removal from State 12/23/2010 Adams-Green Funeral Home Herndon, VA Donation 5 Other Specify 21. Signature of Funeral Service License 20170 Adams-Green Funeral Home 721 Elden St., Herndon, VA 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician een Onset and failure. List only one cause on each line /Medical Death a Contact Gunshot Wound of Head Immediate Cause (Final diseasa Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last physician and the burial - transit edical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery Physician/M 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Day Year for use as past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. á 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of this certificate has death? performed? ✓ Yes 2 No 2 No 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes No 28a Date of Injury FOUND: Day, Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot self FOUND: Natural 1 Yes 2 V No Pending within 24 hours after death.

To the Funeral Director: the Dec 13, 2010 2 0730 hrs Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) Selden Island, Poolesville, MD determined (Spgcify) Field 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 14, 2010 O.C.M.E. 120 30. Name and address of person who completed cause of death (Item 23a) DOME **Deputy Chief Medical Examiner** 111 Penn Street, Baltimore, MD 21201 Mary G. Ripple MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

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			For State		State of M	aryland			f Health and N	Mental Hy	giene	2010	4   1 + 6
			Registrar				Cer	tificate o	f Death		Reg. No.		
	Physicia Medic		1. Decedent's Name (	UJF	Fuhrer					2. Date of De	Day	y Year 2010	3. Time of Death
j	Examin	er	4a. Facility Name (if n	ot@nstitution, give	street and number)	adica.	11.00	4b. City, Towr	, or Location of Death			. County of Death	
ممريد			5. Social Security Nur	1 + 4 0 + /VI	aryland M	e (In yrs. las		If Under 1 Ye	ar I if Under 24 Hrs.	8. Date of Bir		altimor	
	Funeral Director		216-38- Usual Residence of D	-3369 <sup>1</sup>	Дм 2ХД г	6 (in yrs. ias		Months Da		(Month, Date of Bir (12 – 31	av. Year)	Count	olace (State or Foreign try)
	and show	io		10b. County		10c. City,	Town or Loc	cation				1	0d. Inside City Limits
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	ms 2; must	Funeral	4038 Paw	Paw C			Lagra	21863		if \/ \\-	USA		
	or ite	by Fu	11. Marital Status  1  Never Marrie	d 2 Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🛣			Vas Decedent of f Yes, specify C	f Hispanic Origin? (Sp uban, Mexican, Puerto	ecity yes or No- Rican, etc.)		<ol> <li>Race - Americ Black, White, e</li> </ol>	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heathl and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		3 XWidowed 4		If Yes, Give Year or Dates.	NO	1	☐ Yes 2 <b>X</b> ☐	No Specify:			SpedWhite	
5-0	2 hou "natu edical	Completed	(Speci	15. Decedent's Edify only highest gra			(Give I	lent's Usual Ockind of work do	ne dunna most of work	king	16b. K	ind of Business Inc	dustry
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<u>lan</u>	d be filed of filed in the fired other fices of the files	10	Nile Ho	olliday					Helen W	ilev			
аŋ	should and h is ma		19a. Informant's Nam	ne/Relationship (Ty	rpe, Print)		19b. Mailin	ng Address (Stre	eet and Number or Rur	_	er, City or	Town, State, Zip C	Code)
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ore	ge 1 a it of F if ite or oth		20a. Method of Dispo 1 🏻 Burial 2 🔀	sition Cremation 3	Removal from State	ce	metery, cren	sition (Name of natory or other	ÆG€	Date	1	ocation - City or To	wn, State
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		15.0	23a. Part 1. Enter the	disease or comp	plications that caused	the death			lying, such as cardiac			<u>D 21801</u>	Approximate
	Physician/		Immediate Cause (Fi		ne cause on each line		Λ						Interval Between Onset and Death
	Medical		disease or condition resulting in death)	•	a. Scoti								
	Examiner	<u>.</u>	Sequentially list cond	ditions.	b. —								
	sit	Examiner	if any, leading to imm cause. Enter Underly Cause (Disease Or iii	nediate ring	Due to (or as	a conseque	ence of):					10	
	oe executed ician and ourial-transit		that initiated events resulting in death) La		c. Due to (or as	a conseque	ence of):						
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Box 68760	ifficate ng phy as the	Med	IF FEMALE:										
٥ ×	h cert tendir or use	ian/l	23b. Was decedent p in the past 12 m	regnant	23c. If yes, outcome 1 Live Birth			Ectopic pregr	ancy			23d. Date of delive	<u> </u>
Bo	requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medi	1 ☐ Yes 2 ☑ 9 ☐ Unknown	No	4 ☐ Pregnant a 9 ☐ Unknown	at time of de	eath 5 L	Other (specify	)			Month	Day Year
Ö.	at the	/ Ph	Part II. Other signific	ant conditions co	ontributing to death b	out not resu	Ilting in the u	nderlying cause	given in Part I.	23e. Did	tobacco u	use contribute to th	ne cause of death?
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a	rian: ertifica ctor, p	Be (	25. Was case referred examiner?					26	. Place of Death (Chec			*I	
⋛	hysic this co al dire	P	1 ☐ Yes 2 🕜	No				it 3 LI DOA				Other (Specify	)
n o	ding F h. After t funera	Certificate:	27. Manner of Death  1 Natural	5 Pending	28a. Date of inju (Month, Da	ry, Year)	28b. Time of injury	V	njury at vork? Yes 2 No	28d. Describe	how injur	y occurred	
sio	Atten r deat ctor:	ıţį.	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined		ury - At hor	ne, farm, stre			28f. Location (	Street and	d Number or Rural	Route Number.
Division of Vital Records, P.O.	ital or irs after all Directions after all Directions and Directions and all all all all all all all all all al		4 L3 Fiornicide	determined	building, et	c. (Specify)				City or To			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours affer death.  At the Funeral Director. Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2	Medical Exami	iner: On the basis of e	examination	and/or invest	tigation, in my o	ime, date and place, a pinion, death occurred a at the time, date and pla	at the time, date	and place	, and due to the car	use(s) and manner stated.
	To the To the Coape		29b. Signature and tir		7 1.1	,		29c. Lic	ense number		29d. Da	te signed (Month, i	Day, Year)
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	om		30. Name and addres	ss of person who	completed cause of c	leath (Item	23a) (Type, F	Print) Bold	-imore, MI	2120	31		
	Sta	е	31. Date filed (Month)	Pay Year	32. R gistr	ar's Signatu	ure /	1 11	, (*1-4				
	Pegietr			JEL 14	11111 66	WANG 1	19 4	Danka					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Francis Georgia May Vandegrift 1:12 A M 12 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salis bury Coastal Hospice at Wicamica 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🏝 F Months Days Hours Min. 221-28-0517 0270571916 Delaware 94 Director Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Wicomico Salisbury 1 🗶 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21804 USA 1109 S. Schumaker Drive permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1  $\square$  Never Married 2  $\square$  Married 1 ☐ Yes 2 🛣 No If Yes, Give 21215-0036 1 Yes 2 No Specify: Specify: white 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) executive housekeeper hotel 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 Esther W. Anderson Charles W. Townsend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Penny Lane, Salisbury, MD 21801 Roger Vandegrift/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 12/14/2010 Riverview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Wilmington, DE - spature of Funeral Service <sup>22</sup> Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ear hiline. Approximate Interval Between Onset and Death nmediate Cause (Final Physician/ BMBN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day 4 Pregnant 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed within 24 hours a er death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 25. Was case referred to medical examiner? by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 2 No ပု 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 10301CFZ 28c. Injury at work?
1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No (2 Accident Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 mp 6

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month

Day Year)

Barke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 13, 2010 CAROL JEAN FRANK 9:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heartfields at Fred. Assisted Living Frederick Frederick 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1 <u>937</u> 1 M 2 F Months Days Hours July 18, Ohio **Director** 577-50-0882 Usual Residence of Decedent iled within 72 hours after death with the Maryland I Hygiene.

When than "natural", or items 23a or 28a-f show drafter than "natural", or items 2a or 28a-f show ont, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1820 Latham Drive 21701 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Albert Eugene Thobois Martha Louise Petran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 907 North Main Street, Mt. Airy, MD 21771 Julie Frank / Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Department of H Important: If ite Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Olivet Cemetery 12/17/2010 Frederick, Maryland ere Sen ROBERT E. DATLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, 23a. Part 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ALZHEIMER'S DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Yewas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): siclan and burial-transit Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician ause as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Division 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the Sest of my knowledge, death accurred at the time, date and place, and due to the c 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 39444 12 14 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE E, FREDERICK, MD 21702 63 THOMAS JOHNSON DAME 32. Regis r's Signature State arkel Registrar

Box 68760

P.O.

Records.

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Celester Mae Fenne11 December 2010 10:43 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Thomas More Hyattsville Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, 1 M 2 X F Months Hours Min South Carolina Director 578-44-0733 86 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits DC Washington 1X Yes 2 □ No 6 10e. Street and Number 10f. Zip Code iral", or items 23a or Examiner must be r 10g. Citizen of What Country? Funeral 3506 Commodore Joshua Barney Dr. T-2 20018 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Rlack. White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No If Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 ☐ Divorced Specify: Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene.
It is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 6 Domestic Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ of Health and Ments Jimmie Lee Howell, Sr. Collins Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trae Bernestine Sumlar / Daughter 3506 Commodore Joshua Barney Dr. T-2 Wash DC 20018 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 12/15/10 Brentwood, . Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Breta mances 3401 Bladensburg Rd. Brentwood, Md 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.
Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) TUSC Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Day 2 XNo signed by the 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed?

Yes 2 No death? 25. Was case referred to medical B 26. Place of Death (Check only one) 2 🖹 No Hospital: Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident 1 Tes 2 No ☐ Accider
☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 24 (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

DEC 1 4 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1<sup>Month</sup> 26/2010 Arthur Melvin Freeman 07:35 ₺ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7513 Sunburst Ave Kent Chestertown, MD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director Yrs. 28-1958 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a مه 1862 فاسم 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 🗋 Yes 2 🗎 No MDKent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7513 Sunburst Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced SpecifBlack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Janitor Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Arthur Melvin Freeman Mary Virginia Towson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorene Freeman/Wife Sunburst Avenue Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 12/472010 **X**□ Burial 2 □ Cremation 3 □ Removal from State Chestertown, MD 21620 4 ☐ Donation 5 ☐ Other (Specify) Pisgah United Methodist 21. Signature of Funeral Service Livensee CHUR C抖Name and Address of Facility Bennie Smith Funeral Home High Street Chestertown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ancer Medical resulting in death) Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ☐ Yes 2 ☐ No Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 □ No ၉ 1 Tes Other: in 24 hours after usego... he Funeral Director: After this of maleted filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

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J.	Examin	er	4a. Facility Name (if not institution, give str NATIONAL NAVAL M	EDICAL C	ENTER			ВЕ	Location of Deat		4c. County of Death  MONTGOMERY			
	uneral irector		5. Social Security Number 6. Sex 1 3	er 1 Year Days	If Under 24 Hrs Hours Min.		Day, Year	1986	9. Birthp Coun	place (State or Foreign try) CA				
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the M	or 28 e not	Dir	10e. Street and Number				10f. Zip Code					Citizen of W	hat Coun	itry?
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21215-0036 / 700 / Within 72 hours after death with the Maryland	mented other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	b	1 Never Married 2 🔀 Married	2. Was Decedent E Armed Forces? 1 2 Yes 2 1 If Yes, Give 2 Year or Dates.		E 14	f Yes, spe	ecify Cuba	spanic Origin? (Sin, Mexican, Puert Specify:	pecify Yes or o Rican, etc.)	No-		, White, e	an Indian, etc. HITE
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Maryland 21215-0036 2 should be filed within 72 hours after th and Merital Hydiense	than "na he Medic	Completed	(Specify only highest grade Elementary/Seconday (0-12)		——	Ìife. D	kind of w O NOT us	ork done a se retired)	ation luring most of woi	rking	16b.	Kind of Bus		dustry
	other ent, t	Be (	12. 17. Father's Name (First, Middle, Last)	-	i_	U.	S.NA	<u> </u>	18, Mother's Na	me (First, Mid	dle, Maidei	DEFEI n Surname)	NSE_	
/land	irked tic ev	욘	JORGE E. GUADRON						MAR	IA ZAMO	ORA			
Na 12 sho	7 is trau		19a. Informant's Name/Relationship (Type, Print)  MARIA ZAMORA/MOTHER  19b. Mailing Address (Street and Number or Rural Route Number, City or Town 827 NORTH LEMON STREET ANAHEIM CA									ate, Zip C 9280	_	
Saltimore, bermit. Page 1 and	5 = 2		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cem	e of Disponetery, cren	natory`or	other plac	· .	Date		Location - (	-	
altir Per	ortant: I	1	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Jigensee	1 -	GATE	WAY C				22,201		ILLERT		
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<b>₽</b> ,₫	d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury	,		,								
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e death c	To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal de	eath 3 🗆	Ectopic Other (s	pregnanc specify)	у			23d. Date of delivery  Month Day Year		
that th	ed by detac	by Ph	Part II. Other significant conditions contr	ibuting to death b	ut not resultii	ng in the u	nderlying	cause giv	en in Part I.	23e. D	id tobacco	use contrib	oute to th	e cause of death?
Uires 1	n sign ald be									1	☐ Yes 2	2 🔀 No 3	B 🗆 Prob	oably 4 🗌 Unknown
Kecords, The law requires	as bee 2 sho	Completed								24a. V	Vas an utopsy	24b. W	ere autop	osy findings available impletion of cause of
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T VI	this cral dire	<u>۔</u> 1	1 🙀 Yes 2 □ No Pros 27. Manner of Death	1 X Inpatie	ent 2 ER	Outpatien b. Time of			4 ☐ Nursing F	T				
n OT Iding Pt	: After	Certificate:	1 Natural 5 Nending 2 X Accident Investigation	(Month, Day fd 11-19	(Year)	iniury	м	work	at ?Unknown Yes 2 □ No	Un-wi	tness	ed ap	pare	nt fall
UIVISION tal or Attendir rs after death.	ector by the	) Trifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home						n (Street a	nd Number		Route Number,
LIV talor rs afte	al Dir ed in			building, etc	lanama	,Bahr	ain			Unkno	Town, Stat wn	'e)		
Hospi 24 hou	Funer sted fill	edical	29a. Certifier 1 Certifying Physici. (Check 2 Medical Examiner	: On the basis of ex	camination an	nd/or invest	igation, ir	my opinio	n, death occurred	at the time, da	ite and plac	ce, and due t	to the cau	use(s) and manner stated.
o the	o the	Ž	only one) 3 Certifying Nurse F 29b. Signature and title of certifier	ractioner: To the	best of my kn	owledge, d		urred at the		ace, and due t		e(s) and man ate signed		
_ >	- 0		· 4/-		Rouse 6	hwh/L				VA)		rz-10		
			30. Name and address of person who com	pleted cause of de				RMED	FORCES	INSTIT			·	
					C_USA				RESEARCH					
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2144 M Lloyd V. Gillespie 10 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Poninsula Regional Medical XIISbur 8. Date of Birth (Month, Day, Ye Oct. 3, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months 1 🔀 M 2 🗆 F North 247-36-6119 Director 85 Carolina Oct. Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at usy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Snow Hill 1 🗆 Yes 2 🏻 No MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21863 USA 3955 Old Furnace Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 2 □ No 1943 1 Never Married 2 X Married Completed by 1 X Yes If Yes, Give Maryland 21215-0036 1 Yes 2XX No Specify: Specify: white 3 Widowed 4 Divorced 1957 Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing OTR Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ila Lowee Gillespie Jake V. Gillespie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21863 3955 Old Furnace Road Snow Hill, MD Gayle Gillespie/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarval2-11-2010 Delmar, Delaware Signature of Funeral Service Licenses 22. Name and Address of Facility Short Funeral Home Short 19940 Delmar. East Grove Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ina Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) g 🔲 Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MID a1101 31. Date filed (Month, Day, Year) 32. Regist ar's Signature

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ GREENE FREDERICK 2010 20 Medical Facility Name (if not institution, give street and number, **Examiner** City, Town, or Location of Death 4c. County of Death 'A Medical + MURC SACTITUDITE Limure cial Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 M 2 □ F (Month, Day, Yea Hours Director CORTDA Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-1 sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits NICOMICO 1 Z Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or i Black, White, etc. Completed by 1 Never Married 2 Married 2 🗆 No Yes Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: If Yes, Give 3 Divorced BLACK Year or Dates. Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CLENCY フエルエメエヒバ Be 17. Father's Name (First, Middle, Last) မ GREORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zio Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) . Signature of Funeral Service Litensee Kell, xlisbure 23a. Part 1. Enter the disease, or control cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARRYTHMIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Imjury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and normalist of the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death Month Year 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 X No Other: ြု 1 X Inpatient 2 DER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ANA PAUNOVIC

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32 Registrar's Signature

28a-f show must be notified at 0 items 23a Examiner "natural", or Baltimore, Maryland 21215-0036 other traumatic event, the Medical filed within 72 all Hygiene. permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic avona Ph\_sician/ physician and s the burial-transit Box 68760 as by the P.O. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per FH, RG FCHD 12/15/10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month George C. MacGillivray December 2010 Medical 10:15p 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Country Meadows Frederick Frederick 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
Nov. 1, 1922 **Funeral** 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 X M 2 | F Hours Min. Director 015-16-3572 88 Nov. Massachusetts Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8104 Frosty Field Court 21702 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 

Yes 2 □ No Black. White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Cartographer C.I.A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George A. MacGillivray Raymonde Minier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jim MacGillivray/ Son 8104 Frosty Field Court, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of Marchat21, 20c. Location - City or Town, State 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 21. Signature of Emeral Service LC 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) Dementia Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or initiary that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ High bleed Pressure 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2.4 1 ☐ Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) A 55, 54P6 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signature, d title of certifier 29d. Date signed (Month, Day, Year) D 5164

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31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Thomas

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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NO

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 3, 2010 Year Barbara Jane Gracyalny 4:00 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 3920 Ilford Road Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🖵 F March 19, 1934 200-24-6753 Director Yrs Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Silver Spring MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral IISA 20906 3920 Ilford Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine once. Armed Force Black, White, etc. "natural", or δ 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give 1 ☐ Yes Ž No Specify: 3 Widowed 4 ☐ Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Helen Matilda Hughes James Earl Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3925 Ilford Road, Silver Spring, MD 20906 Patricia Gracyalny/Daughter 20a. Method of Disposition Date 30, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Arlington Nat'l Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Arlington, VA 21. Signature of Funeral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cerebrovascular Accident 24 hrs Medical Due to (or as a consequence of): **Examiner** 20 yrs Diabetes Mellitus, Type II Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending the funeral director was provided to the funeral director. 20 yrs Hyperlipidemia that initiated events resulting in death) Last Due to (or as a consequence of): 20 yrs Physician/Medical Hypertension 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Spinal Stenosis, Peripheral Neuropathy, Osteoporosis, Dementia, Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Temporal Arteritis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5x Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number DC13091 29b. Signature and title of certifier 29d. Date signed (Month, Bay Year) December 10, 2010 reuleus Name 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Saulius Naujokaitis, MD 3301 New Mexico Ave., NW, #349, Washington, DC 20016 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1ervin 20 PM 07 December /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☑ M 2 □ F 9, 175-50-6703 57 Oct. 1953 Director Penna. Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show must be notified at 1 ☐ Yes 21 No Director PA. Franklin Greencastle 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code ò 902 Williamson Rd. U.S.A. items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Examiner Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2K Married 2 🔀 No 6 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify Specify: White ģ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other than Mechanical Technician Egg Service 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F is marked ot Margaret Myers Department of Health and Ments Important: If item 27 is marked any injury or other traumatic evence. C. Walter Hock Sr. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 Williamson Rd. Greencastle, PA. 17225 Deborah Hock/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Air Hill Cemetery 12/27/10 Chambersburg, PA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zimmerman And Son Funeral Home 21. Signature of Funeral Service Licenses H. Martin 45 S. Carlisle St. Greencastle, PA. 17225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Imonary /Medical Lue to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician a Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 2 No 9 Unknown the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Jas 2 12 NO 1 TYes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other:  ${}_{4} \square$  Nursing Home  ${}_{5} \square$  Residence  ${}_{6} \square$  Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 Yes ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Yes 2 No 2 Accident Director: A 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 29a. Certifier 1 X-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of co

(o ∨ State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

December 21,2010

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

3altimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11158 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8,2010 Physician/ Month Arnold L. Hindin December 11:57 a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 107 Tolson Street <u>Annapolis</u> Arunde1 Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 8 Date of Birth If Under 24 Hrs Funeral 9. Birthplace (State or Foreign 1 🙀 M 2 🗆 F Months Days Hours Baltimore,MD 06/13/1936 Director 577-46-3873 74 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 ☐XYes 2 ☐ No Annapolis 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 Tolson Street 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates. 55-61 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Meda (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leon Hindin Lucille Griden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jodi Michelle Haugen Daughter 4004 Gregg Court Fairfax, VA 22033 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Maryland Veterans 12/10/2010 Crownsville, MD 21032 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12 Ridgely Annapolis, Mye 21401 Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to humodiate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for della consequence of Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [호 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ thknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has performed 2 🗌 No 1 Tes Yes 2 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 욘 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA funeral in 24 hours after deam.
The Funeral Director: After the "and a in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accider 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge, Jeath and under the time, date and place, and due to the 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PEEDMAN (16 MICHAEL 31. Date filed (Month, Day, Year) State DEC 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ΑM December Charles Richard Holesapple 2010 9:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Calvert Burnett-Calvert Hospice House Prince Frederick If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** West Virginia Hours Min. (Month, Day, Year) 2-04-1944 **Director** 66 217-44-4508 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director notified 1 🗌 Yes 2 🕎 No MD Calvert Owings 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 6012 Clairemont Drive 20736 USA Page 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever III 0.3.

Armed Forces?

1 X Yes 2 □ No

If Yes, Give

Year or Dates. 1965-69 Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. "natural", 3 Widowed 4 Divorced Completed white ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) heavy equipment operator construction and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Η. Holesapple Fred Della Ε. Sturdivant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important; If item 27 Marjorie Pumphrey Holesapple, 6012 Clairemont Driive, Owings, MD 20736 spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) injury or Broomes Island Cem. 12-11-2010 | Broomes Island, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. William R. CINO 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Metastate squawaus clot carrivame of the laryou disease or condition JANV Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for sels consequence of physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 2 No ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 2 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has b irector, page 2 sl autopsy performed? Yes 2 No death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospice After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred House work? 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 8 2010 1)56024 alta 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick MD 20678 dRW 8+1 Kenneth L. Abbot Hospital Koad 110 Suile 110

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

. Registra Signature

32

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 0 4 State of Maryland / Department of Health and Mental Hygiene

Physician/ 1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year			1- For State Registrar		Cert	ificate o	f Death			R	eg. No.		
ACTION OF CONTROL AND CONTROL	Physicia		1 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time										
Bescheltes Road    Secretary   Compared to the property   Compared to the p	Medical Examir	ıer	Olivia Ray Howe December 5, 2010									2040 hrs	
Subject to the control of the contro			4a. Facility Name (if not institution, g	ive street and num	nber)		4b. City, Tov	m, or Loc	cation of Dea	ith		of Death	
219 - 28 - 1716   w sQC   To very More   To College   To very More   To very More			86 Sheckles Road				Hunting	town			Calvert		
219 - 28 - 1716		$\Box$	Social Security Number     6.	Sex 7	. Age (In yrs. las	st birthday)		$\overline{}$		_	rth(MM/DD/YYY		
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The control of the		ŀ						_		1 - 7			
State   Control of C	any		10a. State 10b. County		10c. City, T	own or Loca	tion						121
State   Control of C	pu pu	_	MD Ca:	lvert			Hunt	ing	town				1 X Yes 2 No
State   Control of C	aryla Sa-f	둜	10e. Street and Number				10f. Zip Co	ode		1	0g. Citizen of W	hat Coun	itry?
Second	he M	ᆰ	86 Sheckells	heo.g				206	30		IIS	Δ	
Second	with 13 23 16 110	펼		12. Was Dece				of Hispar	nic Origin? (		)- 14. Race	- Americ	can Indian, Black,
Second	leath	E	1 Never Married 2 Marrie			lf Y	res, specify (	uban, M	lexican, Puer	to Rican, etc.)	Whit	e, etc.	
22. Name and Address of Facility Raymond—Wood F.H., P.A.	ffer o		3 X Widowed 4 Divorce	d If Yes, Give Year	- 140	1	Yes 2X	No s	pecify:		Specify:	Вl	ack
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22. Name and Address of Facility Raymond—Wood F.H., P.A.	72 h	를	Elementary/Secondary (0-12)	College (1-	4 or 5+)	auring n	nost of workir	g ille. D	JNOTusen	eurea)			
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22. Name and Address of Facility Raymond—Wood F.H., P.A.	the Name	Ŝ	17. Father's Name (First, Middle, La	st)				18.	Mother's Nar	ne (First, Middle,	Maiden Surname	;)	
22. Name and Address of Facility Raymond—Wood F.H., P.A.	21 be fill rked	8	Thomas Ray										
22. Name and Address of Facility Raymond—Wood F.H., P.A.	D 21					19b. Mailin	g Address	Street ar	nd Number o	r Rural Route Nur	mber, City or Tow	m, State,	Zip Code)
22. Name and Address of Facility Raymond—Wood F.H., P.A.	MC d 2 sl d 2 sl lth ar		Pandora Brooks	s/Daugh	ter	950	Ponds	Wo	od Ro	ad, Hur	ntingto	wn,	MD 20639
22. Name and Address of Facility Raymond—Wood F.H., P.A.	re, s l an f Hea							of cemet	ery,	Date	20c. Location	- City or	Town, State
22. Name and Address of Facility Raymond—Wood F.H., P.A.	Pages					. Mem	'1 Ga	rde	ns   12	/9/10	Dunki	ck,	MD
23a Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardae or respiratory arrest, shock, or heart failure. List only one cause on each line immediate Cause (Finish disease) at Atherosclerotic Cardiovascular Disease or condition resulting in death)   Approximate Interval Benever and	alti mit. partm ports	ı				22. 1	Name and Ad	dress of	Facility R	avmond	-Wood I	г.н.	. P.A.
Physician interest in the control of	E F P P		6. W00			P	О Вох	43	0, Du	nkirk,	MD 207	754	,
Immediate Cause (Final disease of condition resulting in death)   Due to (or as a consequence of):	Physician	T			used the death. I	Do not enter t	the mode of o	lying, suc	ch as cardiac	or respiratory arr	est, shock, or he	art	
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UNPENDED   AMENDED   AME		<u> </u>	cause. Enter Uniterlying Cause		consequence of):								
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29b. Signature and title of certifier  29c. License number O.C.M.E.  December 7, 2010  30. Name and address of person who completed cause of death (Item 234) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	387 rtific ling p						etal death	3	Ectopic preg	nancy	Month	D	ay Year
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	JRW D		Zabiullah Ali, M.D. Ass	sistant Medica	l Examiner	`111 Per	nn Street,	Baltim	ore, MD 2	1201			
		_			istrar's Signature	A L	a. e. D						

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Charles Hardison Ž010 10:26 a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Calvert Calvert Memorial Hospital Prince Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day, Year) 1 X M 2 □ F Hours Min Director 63 264-92-7127 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 X Yes 2 No MD Calvert North Beach 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 9236 Erie Avenue 20714 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ▼ Yes 2 □ No
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1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEART 1 🗆 Yes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed this certificate 2 🗌 No Yes 2 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5 Pending 2 Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasts of examination allows investigation, in this opinion, weath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 12/8/2010 PRINCE PREDERICK, MD 20678 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) A M0007 (10 HO, CP NAC MO 31. Date filed (Month, Day, Year) 32. Registra Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12/9/2010 Day CHARNITA HAMILTON 6:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕱 F 9/5/1959 Director 577-80-4395 Washington, Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5100 Heath Street 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. þ 1 Never Married 2 X Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: Completed 3 - Widowed 4 - Divorced Year or Dates **Black** the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ced other than " Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Registered Nurse DYR Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injuy or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Clarence Rivers Delores Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Ham<u>ilton / Husband</u> 100 Heath Street Capital heights, Maryland 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 🔀 Cremation 3 🖵 Removal from State 4 Donation 5 Other (Specify) Riverdale, Maryland Riverdale Park 21. Signature of Funeral Service Li 22. Name and Address of FacilityPope Funeral Homes, P.A. MOLOSS 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ERFORATE STOMACH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ğ Month Dav Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2Æ 9 ☐ Unknown P.O. ò signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate 1 ☐ Yes 2 ☐ No Yes 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Aatural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Currifying Nursu Praction at the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner at stated. To th. (Check only or 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, 09 2050 any and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive Cheverly, Maryland 20785 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DEC 1 4 2010 **State** Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2010

			For State	State of Maryland							21	110	partie of	161.
			Registrar  1. Decedent's Name (First, Middle, La	st)	Cer	tiricat	e of D	eatn		2. Date of Dea	Reg. No. —	<u> </u>	3. Time o	f Death
P	hysicia Medic		Roscoe Harris Sr. Month Day Y									Year 7.∏	4:40	ΔM
` .	Examin		4a. Facility Name (if not institution, give	e street and number)			Town, or				4c. Cour	nty of Death		
ما المحد			Holy Cross Hosp  5. Social Security Number   6.5		et hirthday)		lver	<u> </u>	ing er 24 Hrs.	8. Date of Birt		tgomer	ry place (State o	or Foreign
	uneral irector			M 2 □ F 63	Yrs.	Months	Days	Hours	Min.	Month Day		Coul	ntry) NC	or roreign
ס	t ow	L	Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Loc	ation							10d. Inside C	ity Limita
arylan	a-f sh fied a	ecto												s 2 $\square$ No
the M	or 28 e noti	Dir	10e. Street and Number	George's	<u>Landov</u>		p Code				10g. Citizen o	of What Cou	intry?	
، with	nust b	Funeral Director	7805 Pacer Ct.				207	785			AZU			
death	r item iner n		11. Marital Status 1 ☐ Never Married 2 ★Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No	. 13. V	Vas Dece Yes, spe	dent of His cify Cubar	spanic O n, Mexica	rigin? (Spe an, Puerto	cify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc.		
<b>ວ-ບບວດ</b> 2 hours after	ral", o Exam	ed by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♠ No If Yes, Give Year or Dates.	1	☐ Yes	2 XNo	Specif	y:		Spec	ify: Bla	Black	
2 hour	"natu	Completed	15. Decedent's I	Education	16a. Deced	ent's Usu	ial Occupa	ation	st of worki	na	16b. Kind of			
thin 7	than the Me	Som	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO	NOT us	e retired) rator				Too	nenoni	tation	
Ied w	other ent, t	Be	17. Father's Name (First, Middle, Last)	ΙL	Bus	vhe	acoi		her's Name	e (First, Middle,			Cacion	
Yland Ild be filed Mental Hy	arked atic ev	잍	Charlie R. Harr	ris				Co	ora B	ell Wal	ters_			
Mar 2 shoul	Importants if them 27 is marked other than "naturals", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship ( Annie M. Harris	**						l Route Number Ver 1 MD		, State, Zip	Code)	•
Tand Tand	item		20a. Method of Disposition	20b. P	lace of Disposemetery, crem	sition (Na	me of	ام	[	Date	20c. Locatio	n - City or T	Town, State	
Saltimor bermit. Page 1	ant; I		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	I Removal from State	shingt	on N	ation	īal	Cem /	2-11-2010	Suitl	and 1	MD	
<b>Danit</b>	Import any inj once.		21. Signal of Funeral Service Lic in	trubland			nd Addres Alle		un Rd	trickla Camp	nd Fun Sprin	eral ( gs, M)	Service D 2074	es B
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only										Approxima Interval Be	ite
	sician/		Immediate Cause (Final disease or condition	Multiple		a							Onset and	Death
	fedical aminer		resulting in death)	Due to (or as a consequ		lure								
-		ner	Sequentially list conditions, if any leading to in manual cause. Enter Underlying Cause (Disease or iinjury	b. Due to or as a conse u										
cuted	nd transit	Examiner	that initiated events	c. Hyperkal										
<b>bU</b> ate be executed	physician and the burial-transit	alE	resulting in death) Last	Due to (or as a consequ	ence ot):									
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certific	ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnal		Ectopic	pregnance	v			23d.	Date of deli	very	
BOX e death c	the att hed fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown		Other (s						Month	Day	Year
tat i	ed by detac	by Ph	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying	cause giv	en in Pa	rt I.	23e. Did to	bacco use co	ontribute to	the cause of	death?
dS, I	en sigr uld be								-	1 🗆 1	Yes 2 N	o 3 □ Pr	obably 4	Unknown
aw rec	as bec 2 sho	Completed								24a. Was		prior to c	opsy findings completion of	available cause of
P P	cate h	Con								perfo 1 ☐ Yes	rmed? 2 No	death?	2 No	
VITAL KECOFGS, Iysician: The law requires	certifi	Be G	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:			104	or.	eath (Checi					
OT V	erthis ierald	e: To	27. Manner of Death	1 No Inpatient 2 2 28a. Date of injury (Month, Day, Year)	28b. Time of		28c. Injury	/ at		ome 5 🗌 Resid 28d. Describe h			<i>fy)</i>	
On endin eath.	or: Aft	fical	1 Natural 5 ☐ Pending 2 ☐ Accident Investigatic 3 ☐ Suicide 6 ☐ Could not	on	injury	M	work'	Yes 2	□ No					
UIVISION tal or Attendir rs after death.	Directed in by t	Certificate:	4 Homicide determined		me, farm, stre )	eet, facto	ry, office				8f. Location (Street and Number or Rural Route Number, City or Town, State)			
Hospita	Funera ted fille	Medical	(Check 2 L Medical Exar	ysician: To the best of my know! niner: On the basis of examination	and/or invest	igation, ir	my opinio	n, death	occurred a	t the time, date a	nd place, and	due to the c	:ause(s) and m	anner stated.
FEMALE:   23b. Was deceded to pregnant in the past 12 months?   1   Yes 2   No 3   Probably of the past 12 months?   1   Yes 2   No 3														
F ≥	0		PROPERTY SI	hollm.	4		D41					08/20		
10	10		30. Name and address of person who	completed cause of death (Item	23a) (Tybe, F	Print)	C		C*	- MT -	חפים			
10	10		Bergit Schoellmar	_		KQ. 1	211/	ver	2prin	מוז ב	חקבה			_
	Stat Registra		31. Date filed (Month, Day, Year)	32. Register's Sign	and I									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Day 20 Par 0 1:43 P Jeannette Patricia Huesman Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing Home Berlin Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 91 yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 DX Months 6-28-1919 Director 216-16-9730 Yrs Usual Residence of Decedent or 28a-f shov tr of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Ocean City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12626 Torquay Road 21842 USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Black, White, etc. Sman, Jeannette imore, Maryland 21215-0036 be filed within 72 hours after Yes 2 X No If Yes. Give 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify. Year or Dates white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Malstron Bessie Webster t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12626 Torquay Road Ocean City, MD 21842 Betty Hyle- Daughter permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1  $\stackrel{\mbox{\scriptsize M}}{\longrightarrow}$  Burial 2  $\stackrel{\mbox{\scriptsize D}}{\square}$  Cremation 3  $\stackrel{\mbox{\scriptsize D}}{\square}$  Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Sunset Mem. Cemetery | 12-11-10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes 2 € 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes 1 L. Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No nours after death.

neral Director: Aft Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State, within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signatur and title of certifier Date signed (Month, Day, Year) License number

State Registrar

9715 Healthway Drive Berlin, MD 21811

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Registrar's Signature

Savage CRNP

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Pennie

31. Date filed (Month, Day, Year)

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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ HANNA oces Medical 4a. Facility Name (if not institution, give street and number, **Examiner** Berl If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 0 APRIL 6 1 □ M 2 🔀 F 84 Director 196-18-8736 Usual Residence of Decedent O or 28a-f show notified at 10b. County 10c. City, Town or Location Director DELAWARE SUSSEX FRANKFORD 10f. Zip Code 10e. Street and Number ò 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Completed by Funeral 34469 PYLE CENTER ROAD 19945 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1210712010 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 21215-0036 1 ☐ Yes 2 🗓 No 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. tant: If item 27 is marked other than HOMEMAKER Be 17. Father's Name (First, Middle, Last) Maryland ည Dob JACK McNEAL DOROTHY 19a. Informant's Name/Relationship (Type, Print) DONNA C. SCOTT/NIECE permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
SPRING HILL MEMORIAL
GARDENS 20a. Method of Disposition Date 410611926 1 X Burial 2 Cremation 3 Removal from State 12/14/10 4 Dopetion 5 Other (Specify) 21. Signal/ry/ 1 Fun ral Service Licens 22. Name and Address of Facility us 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) D08 Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the burial-transit 8736 that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical QC, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Pregnant at time of death 5 Other (specify) Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, HOCHR 24a. Was an cate has b page 2 sl autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate Formpleted filled in by the funeral director, page Socia Volue Rephrenent 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Hanna, Doloke 2 No ၉ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier D0045688 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3111 9733 Deir 6. Motinez 31. Date filed (Month, Day, Year)

2010

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State of Maryland / Department of Health and Mental Hygiene 3. Time of Death O T Year 1:10 OIOS County of Death 4c. JORCES I ER 9. Birthplace (State or Foreign Year) 926 PENNSYLVANIA 10d. Inside City Limits 1 🗆 Yes 2 📈 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc WHITE Specify: 16b. Kind of Business Industry OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34469 PYLE CENTER ROAD, FRANKFORD, DE SALISBURY, MARYLAND HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE Approximate Interval Between Onset and Death 23d, Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$  Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner No the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 11815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 6.2010 DECEMBER 8:04A JACOB THOMAS HANSBROUGH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Days (Month, Day, Year) May 4, 1985 25 Maryland 216-19-0065 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland al Hygiene. "natural", or items 23a or 28a-f sho 10c. City. Town or Location Director Taneytown Maryland Carroll 1XX Yes 2 🗌 No 10e Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 21787 260 E. Baltimore Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: white Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Artwork Free Lance Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked oth Maria Jardeleza James D. Hansbrough, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Hansbrough, mother 260 E. Baltimore St. Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Joseph Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/11/2010 Taneytown, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home . Signature of Funeral Service Licensee 136 E Baltimore St, Taneytown, MD 21787 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acute Myocard Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) pronary Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Kawasa that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) Pregnant at time of death the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No **Director:** After this certific I in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA ᅆ 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work death. 1 🗌 Yes 2 🗌 No Accident Suicide Investigation

Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse-Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature WJL 2010

State

DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Day US Physician/ Hogan 0226 M Patricia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Center Carroll Westmuster Carrol Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6, Sex 7. Age (In vrs. last birthday) Country) NY **Funeral** 1 □ M 2🛣 F Days Hours Min 1272771941 Director 68 093-34-8890 Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Union Bridge MD Carroll 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 542 Shriner Ct. 21791 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. Completed by 1 Never Married 2 Married Yes, Give 2 XNo Specify: White 1 ☐ Yes 2 XNo Specify: 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel Bender Charles Donnelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1066 Storm Store Rd., Gettysburg, PA Edwin Calderon/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State Carroll Cremation 12/9/2010 Hampstead, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Lyensee nu 21157 412 Washington Road, Westminster, MD 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mulh Immediate Cause (Final Physician/ 4 ears disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? Completed by 1 Pres 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy this certificate 1 Yes 2 No ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No Hospital 잍 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manne Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d, Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of a 29c. License number 29d, Date signed (Month, Day, Year) WJL 31660 6/10 21157 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMISTER STUNER Average HUMKS GALWW My M MARYLA 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 04 2010 9:11 AM Alfred Richard Hall, Jr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Westminster Carroll Hospice Dove House Birthplace (State or Foreign Country)
 MD Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Min. Hours 1 🛛 M 2 🗆 F 5/30/1924 86 **Director** 217-16-2676 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Director 1 Yes 2 XNo Westminster Carroll MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21157 709 Redwood Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1942þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 1943 Completed 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) C&P Telephone Repairman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude Little ပ Alfred Richard Hall, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1026, Westminster, MD Michael Hall/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/8/2010 Meadow Branch Cem. 4 ☐ Donation 5 ☐ Other (Specify) Westminster, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a conse uence of) Examiner amii Executation list acriditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit cced Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical no mo law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Miknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2. 1 Tes 2 1 Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Detrier (Specify) 1000 2 THVC 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 1 Yes 27. Manner eath 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred HOUSE Certificate: atural 5 Pending 1 🗌 Yes 2 🗋 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 🗆 30 TIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Malcolmoline, Westminster MD a neus

State Registrar 31. Date filed (Month, Day, Year)

**DEC 07** 

2010

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5.44 DM M Hackett 2 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death City, Town, or Location of Death **Examiner** River hester hestertown Manor Kent If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F 8 3 Months Hours Min -76-938 Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10a, State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 ₩ No MD Kent Millington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10734 Chesterville Forest Road 21651 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. ō 1 X Never Married 2 Married ð Yes 2 XIO Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Specify: Black "natural", Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled 00 Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter HACKETT Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 373 Hurtt Ave. Millington, MD 21615 Annetta Graves Niece 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesterville
Cemetery 20a, Method of Disposition 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/13/2010 Millington, MD 21. Signatur of Freeral Service 22. Name and Address of Facility 22. Name and Address of Facility Bennie Smith Funeral Home 855 High Street Chestertown, MD 21620 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ DN665114 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): l by the attending physician and stached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ RETARDATION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed eral Director: After this certificate filled in by the funeral director, pag Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2/ No Other: 0 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Name Pranticing Spanish of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Name Pranticing Spanish (Check within 2

To the I

comple 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) မှ 00060301 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Prin 2) Show by SES CHESTENTOWN, W 2600 MICHAER EI MON W 31. Date filed (Month, Day, Year) State DEC 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 23a, pt. II, 24b, 25 per me g912 2-25-11 vt

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month KAREN JOYCE HILL NOVEMBER 3:45 A 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1519 Goldsboro Road Ingleside Oueen Anne's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Months Days Hours Min (Month, Day, Year) 1/17/1958 **Director** 220-78-9145 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No QUEEN ANNE'S INGLESIDE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1519 Goldsboro Road UNITED STATES 21644 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 lith and Mental Hygiene.
27 is marked other than ' Elementary/Seconday (0-12) 12 College (1-4 or 5+) Bar Manager Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) irmit. Page 1 and 2 should be f spartment of Health and Menta portant: If item 27 is marked y injury or other traumatic ev 2 George John Fox Alice Mary Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Hill / Husband 1519 Goldsboro Road Ingleside, Maryland 21644 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 12/03/2010 Chester, Maryland nature of Funeral Service Licenses 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral
130 Speer Road Chestertown, Maryland P.A. te death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Complications of Chronic Obstructive

Pulypnary Disease (COPD) 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition Medical Examiner resulting in death) De to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed sician and burial-trans CERTIFICATION APPROVED BY MEDICAL Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a d be detached f 1 Yes 2 U Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag Yes 2 No Yes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury 1 ☐ Yes 2 ☐ No Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D23867 12-3-2010 Life 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) se of death (Item 23a) (Type, Print)
115 SNII:tH Drwe, Stevensville MD 21666 THOMAS WARH MD ms 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12706/2010 RUBY ODESSA HALL 2:48 A Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgamery Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/22/1934 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛱 F Days Country) Director 220-34-3541 Yrs 76 Usual Residence of Decedent show 10a. State 10c. City. Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f sl Examiner must be notified 1 🖁 Yes 2 🗆 No MD Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4207 Byers Street 20743 USA Department of Health and Mental Hygiene, Important: If item 27 is marked other their, any niury or other traumer-any niury or other traumer-once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 24 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 Tes 2 No Specify: If Yes, Give Specify: Black 3 Widowed 4 Noivorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Washington Hospital College (1-4 or 5+) 12th Maid Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harold Thompkins Goldie Spriggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Hall/daughter 4207 Byers Street, Capitol Heights, MD 20743 20a. Method of Disposition
1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Cremation Svc 12/08/10 Hanover, MD Signature of Funeral Service Licer 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the diseas or compli ions that caused the death not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only of cause on each line Interval Between Onset and Death instant Immediate Cause (Final Physician/ disease or condition resulting in death) Acute coronary syndrome Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
g ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year cate has been signed by the page 2 should be detached g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Stroke Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 unknown Peripheral vascular disease 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has autopsy Renal failure performed? Yes 2 XN 1 🗌 Yes 2 **X**No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital မ 1 Yes 2X No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred **X**Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nuse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D28656 12/06/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, MD 15245 Shady Grove Road, #130, Rockville, MD 20850

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

08 20H

DHMH 17 Rev 1/200

State Registrar 31. Date filed (Month, Day, Year)

illian Holland

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician/ 1:45 AM 12 2010 James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Coastal Hospice the Lake Schsbury 4 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day Yea 4-2-1928 Days Hours 1 🛛 M 2 🗆 F Maryland 213-22-8745 82 Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Mary/and Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown an injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 X No Hebron Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 7336 Levin Dashiell Road 21830 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 2 □ No 1946-Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Divorced 4 Divorced 1948 Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Horse Racing Trainer/Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Belle James Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Levin Dashiell Road, Hebron, Maryland 21830 <u> Shirley James - Wife</u> Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12-12-2010 Hebron, Maryland Hebron Cemetery 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licenses 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner il any, leading to immediate cause. Enter Underlying Cause Disease or iinjury Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 1 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2: performed Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2/1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hugten 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Decemb Rudolph Robert Jefferson 0956 M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Ponina IIA Regional Medical salisbur Willmill Center If Under 1 Year If Under 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** oct. 28 1 🔀 M 2 🗆 F Days Min Months Hours Delaware 221-20-5267 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗗 Yes 2 □ No Delmar Sussex 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral **USA** 19940 401 Holly Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: Black 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Sussex County Public Elementary/Seconday (0-12) College (1-4 or 5+) Custodian 12th School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edward Jefferson Catherine M. Horsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health 2564 Archdale Drive - Virginia Beach, VA 23456 Donald Williams/ Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot SBurial 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory Gardens, 12/20/2010 Hebron, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Salisbury, MD 22. Name and Address of Facility Jolley Memorial Chapel- 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications hat caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mouse of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause Enter Industrying. Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death 9 Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Mann f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury 2 🖵 No Accident Investigation 24 hours after deat e Funeral Director: 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: Tothe gest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practioner: Tethe lest 3 🗆 To the within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of p who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State 5

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 11:20 AM Dorothy Lucretia Johnson December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County 17629 Homewood Rd. Hagerstown Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day Year) 12 • 18,1928 1 □ M 2 🂢 F New York 134-26-9706 Director 82 Aug. Usual Residence of Decedent show 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Washington County 1 ☐ Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17629 Homewood Rd. 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working alth and Mental Hygiene.

27 is marked other than "r traumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Lab Tech. Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Archiball Hinds Rosa Brown Hinds 1 and 2 should b f Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucretia S. Jefferson-daughter 17629 Homewood Rd. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot Indiantown Gap 1 XBurial 2 Cremation 3 Removal from State 12-16-2010 Annville, PA 4 Donation 5 Other (Specify) National Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebro vos allen disease or condition resulting in death) MONIL Medical Due to (or as a consequence of): Examiner 34eous Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and for use as the bunal-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical been signed by the attending p should be detached for use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🕏 No
9 ☐ Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No certificate has page 2 death? 1 Yes 2 Joho To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medica 8 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 읻 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗆 No 1 Yes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1228365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sheel Halsterum MAN2 368 SHAF 31. Date filed (Month, Day, Year) . Degistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

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Box 68760	eath certificate be attending physici for use as the bu	Physician/Medical	IF FEMALE:										
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•			30. Name and address of person		leath (Item 2	3a) (Type, F	rint)						
1	-7		Jagdish C. Ske					Suite	210 Bow	ie, M	Maryland	20715	
	Stat Registra		31. Date filed (Month, Day, Year) <b>NFC 1 0 2010</b>	32. Registra	ar's <del>Signatu</del>	all	٠.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Herman Sanford Jackson 4, 2010 Dec. 8:40 a. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Longview Nursing Home Manchester Carroll Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 218-40-1423 85 Director 6/20/1925 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "decical Experiment must be neutified at 1 ☐ Yes 2 ☐ No Director MD. Carroll Manchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4350 Alesia Road 21102 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc 1 □Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important; If Item 27 is marked other the any injury or other traumatic coverfarmer farming 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Earl Jackson Carrie E. Berends ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alvina J. Ganjon, sister 4350 Alesia Road, Manchester, Md. 21102 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/6/2010 Hampstead, Md. 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00741 Eline Funeral Home Stand 934 S. Main St., Hampstead, Md. Lemmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Molluto Immediate Cause (Final **Physician** Non NER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as IF FEMALE: esn yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day for in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No P.0. the detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 No 2 No 1 Yes r Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir 2 Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; Natural 5 Pending investigation 1 ☐ Yes 24 hours after death.

Funeral Director A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 24 hor To the Fune completely fi cal (Check only one) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 51705 12-06-2010 ambura. MI) WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Westminster, MD 21157, M. PANSIIRIYA 349 Malcolm DR. Westminster, MD 21157,

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

**DEC 0** 7

2010

parke

32. Registrar's Signature

	Please 1	ype or Print in Bla State of Maryland				_	Z T1 1 2	4117
	1 - State Registrar		Cei	rtificate of	Death	Re	g. No.	
	1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
ian cal	E	llery Karl John	rson			December	Day Year 2010	
ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	
	Holy Cros	s Hospital			ver Spring	3	Mov	itgomery
	5. Social Security Number 6. Sex	IM all E		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)   C	thplace (State or Foreigountry)
	301-03-4822	95	Yrs.			01/09/	1915	Nebrasko
	Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Town or Lo	cation				10d. Inside City Limit
힏	Maryland Prince	George's		,	il Contra			1 ☐ Yes 2 ☑ N
Directo	10e. Street and Number	seonge's		10f. Zip Code	ilver Spri		g. Citizen of What C	ountry?
0	3160 Gracefield R	and ETOO10			20904			S.A.
Funeral		12. Was Decedent Ever in U.S.	13. \	Vas Decedent of I		ecify Yes or No-	14. Race - Am	
ᆵ	1 Never Married 2 1 Married	Armed Forces? 1 ☐ Yes 2 🔀 No			Hispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, Whi	
b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I∐Yes 2 <b>⊠</b> No	Specify:		Specify:	White
Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	ient's Usual Occup	pation	1	6b. Kind of Business	/Industry
n pk	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kina of work done DO NOT use retire	during most of working)	ng		
5		5+		Chemical	Engineer		U.S. Go	vernment
Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
ဥ	Augus	t Johnson				Edlo	ı M. Ekmar	L
	19a. Informant's Name/Relationship (Type	pe. Print)	19b. Mailir	g Address (Street	t and Number or Rura	al Route Number,	City or Town, State,	Zip Code)
	Nancy L. Johnson				on Avenue,	Glen Bu	urnie, MD	21061
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	amoval from State 20b. Plac	e of Dispo etery, cren	sition (Name of natory or other pla	ce)	Date 2	0c. Location - City or	Town, State
L	4 □ Donation 5 □ Other (Specify)		Linco	ln Cemet	ery: 12/1	1/2010 1	Brentwood.	Maryland
1	21. Signature of Funeral Service License	11/2 = 123	2 22	. Name and Addre	ess of Facility Hiv	res-Rinal	edi Funera	l Home, In
	MATINEMATIE	warner	11.	800 New 1	Hampshire	Ave., Si	ilver Spri	ng, MD 209
	23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death.	Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Immediate Cause (Final disease or condition	Cerebrovas	scul a	r Accidos	nt.			Onset and Death
	resulting in death)	Due to (or as a consequen						
<b>L</b>	Sequentially list conditions							
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ice of):					
(am	Cause (Disease or injury that initiated events resulting in death) Last							
l — I	resulting in death) Last	Due to (or as a consequen	ice of):					
lica	d							
Physician/Medica	IF FEMALE:	0-14						
ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de	eath 3	Ectopic pregnanc	су		23d. Date of de Month	livery Day Year
/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of deal	th 5 🗆	Other (specify) _			World	Day Teal
	Part II. Other significant conditions con	tributing to death but not resulting	a in the ur	iderlying cause of	ven in Part I	23e Did toba	acco use contribute t	o the cause of death?
l by		moduling to death but flot lestitll	A III AIIA AL	conying cause giv	ron in Edit I.			
eted						Yes	, ∠µµ № 3∐ F	robably 4 🗌 Unknow
Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Co						performe 1 □ Yes 2	ed? death?	s 2 No
Be (	25. Was case referred to medical examiner?				26. Place of Death			
ဂ္	1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 🔀 ER			4 LI Nursing Hor	me 5 🗌 Residen	sce 6 ☐ Other (Spe	ecify)
ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	lb. Time of Injury	28c. Inju		28d. Describe how	v injury occurred	
cati	2 Accident investigation 3 Suicide 6 Could not be				]Yes 2□No			
Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or Fi State)	ural Route Number,
	One Coulding 197 a 111	1 -						
edical	(Check only 2 Medical Examir	ician: To the best of my knowle ner: On the basis of examination	dge, death and/or inv	occurred at the ti	ime, date and place, opinion, death occurr	and due to the car ed at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	one)	and manner stated.						, ,

State Registrar

Andrew George Kundrat, M.D., 3110 Gracefield Road, Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year)

DEC 08 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

D0036716

29d. Date signed (Month, Day, Year)

December 07, 2010

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Physician/ Month William 240 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbur VICOMIC <u>Peninsula Regional Medicul</u> centa If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months (Month, Day, Year, Min. 64 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho mportant: If item 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Funeral Director 1 Yes 2 No Pocomoke Worceste Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? U.S.A. 2356 21851 Worcester 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Black 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Warcester County Bd. of Ed. 12th grade 6 4 ears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nadine Jones Nathan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jones III -Son S+ 616 Market , focomoke William City, Md., 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Pocomoke 4 Donation 5 Other (Specify) 12-11-10 ilch U.M.C. Cemetery 22. Name and Address of Facility Ward F.H. 21. Signature of Funeral Service Licensee Anthony E. Princess Anna, Ml 21853 A've, Hampden 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Adenocarcinoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the luneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Dav 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 🗌 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 N Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) SHISBURY 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Glen M. Kruse December 2010 6:10 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Crofton Anne Arundel Crofton Care & Rehabilitation Ctr. Social Security Number 8. Date of Birth
June 9, 1923 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Illinois **Funeral** XX M 2 □ Days 87 Director 361-14-4297 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20715 8907 Harness Way 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 X Widowed 4 Divorced Year or Dates. W.W. II Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Purchasing Agent American Can Company vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orlin O. Kruse Marjorie Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Bellay/ Daughter 8907 Harness Way, Bowie, Maryland 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State Important: It any injury or Kalas Crematory 12/9/10 Edgewater, MD 4 Donation 5 Other (Specify) rel | wice Licensee 21. Signatu 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. ch line. Immediate Cause (Final Onset and Death Ph sician/ Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this course. ohysician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy 1 🗌 Yes 2 🗌 No Yes 2 - No 25. Was case referred to \_\_\_\_ical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🖵 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one eath (Item 23a) (Type, Print) nd address of person who completed cau Tidewater Colony Dr., Annapolis, MD 21401 Jennifer Frey 2007 Registrar

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van Kullberg		State 1- For State	of Maryland	•			ntai Hygiene	401	0 -110	
		Registrar		Cerun	icate of Dea	aırı	I	Reg. No.	Ta	
Physicia		Decedent's Name (First, Middle,Last					2. Date of D _Month	Day Year Per 3, 2010	3. Time of Death 0505 hrs	
Medical Exami	ner	Evan Andrew Kull	Decemb of Death							
		4a. Facility Name (if not institution, give 82 East Main Street Apartr	4c. County of Dea	atn						
Funeral		5. Social Security Number 6. Se	, i			nder 1 Year If Und	so I Min	Birth(MM/DD/YYYY) 9. I For	eign	
Director		151 90 7088 <sub>1</sub> X	M 2 F	23	Yrs.		12/29	9/1986	Country) NY	
<b>b</b>		Usual Residence of Decedent		10 0: -					14011 14 00 11 0	
w an		10a. State 10b. County		,	wn or Location				10d. Inside City Limits	
Maryland <b>28</b> a-f show any <u>d at once,</u>	ĕ	MD Montgome	ry	Gaithe	ersburg				1 XYes 2 No	
Mary 28a- d at	Director	10e. Street and Number	<b>T</b>			Zip Code		10g. Citizen of What Co	-	
with the Maryland ns 23a or 28a-f sho be notified at once		133 Fountain Gr	een Lane		4	20878		United S	tates	
n with	Funeral	11. Marital Status	12. Was Decedent Armed Forces?				rigin? (Specify Yes or I in, Puerto Rican, etc.)	No- 14. Race - Am White, etc.	erican Indian, Black,	
deat or ite	틧	1 Never Married 2 Married	1 X Yes 2	No			in, r dono rodan, did.)		nite	
after al", e	à	3 Widowed 4 Divorced	Specify:							
natur Xam	핗	15. Decedent's Education (Specify on				al Occupation (Give working life, DO NO		16b. Kind of Busines	s/Industry	
6 1721 1721 1981	힐	Elementary/Secondary (0-12)	College (1-4 or	5+)	g	g	,,			
5-0036 led within 72 hours after Eygiene. other than "natural", the Medical Examiner	Completed		Food Ind	ıstry						
5-00 illed with Hygiend other		17. Father's Name (First, Middle, Last)		er's Name (First, Middle	e, Maiden Surname)					
WD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she maite event, the Medical Examiner must be notified at once	Be	John Francis Ku		1.	Ant BATT ALL		ol Runing			
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.	리	19a. Informant's Name/Relationship (Tyrkarol R. Kullber						umber, City or Town, Sta		
nd 2:		aithersburg								
S 1 a of He If ite	200. Location - City	or Town, State								
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic	Gaithers	ourg, MD								
alti rmit. spartr sport jury		21. Signature of Funeral Service Licen:	see	-	Rose of I sh Cemete 22. Name a	nd Address of Facil	<sup>ity</sup> Joseph Ga	awler's Son	s, Inc.	
ED 8 Q E .E		W. letty Mil	May			Visconsin		Washington,		
Physician		23a. Part I. Enter the disease, or compl failure. List only one cause on ea		the death. Do	not enter the mod	le of dying, such as	cardiac or respiratory	arrest, shock, or heart	Approximate Interval Between Onset and	
Medical Examiner	- 1		Smoke Inhalatio	n					Death	
<u> </u>		or condition resulting in death)	Due to (or as a conse	equence of):						
	اب	Sequentially list conditions, b.								
	<u>.</u>	cause. Enter Underlying Cause	Due to (or as a conse	equence ot):						
Q .	Examiner	events resulting in death) Last	Due to (or as a conse	equence of):						
executed an and al - transit		d								
	ical	UNPENDED	AMENDED							
68760, certificate be nding physicis	š	IF FEMALE:	23c. If yes, outcom	ne of pregnanc	су			23d. Date of deliv	ery	
687 ertific ding 1	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal dea	th 3 Ectop	oic pregnancy	Month	Day Year	
Box 68 c death certificate attending	Sici	1 Yes 2 No 9 Unknown		time of death	5 Other (S	pecify)		K.		
<b>©</b> å å <b>©</b>	Physician/Med	Part II. Other significant conditions	9 Unknown contributing to death	hut not result	ting in the underly	ing cause given in E	Part I 23e Dir	tobacco use contribute	to the cause of death?	
rds, P.O. requires that the been signed by hould be detach		, are in ordinary organical contains	contributing to death	T Dat Hot resum	ang in the underly	ing cause given in i		'es 2 ✓ No 3 P		
S, luires	Completed by					<del></del> ·	24a. Wa		autopsy findings available	
cords, law requir has been s	De le	-					aut	opsy prior t	completion of cause of	
Rec The la	E							formed? death′ s 2 ✓ No 1	Yes 2 No	
al F an: `an: ctor, p	Bec	25. Was case referred to medical					h (Check only one)			
on of Vital Records, tending Physician: The law requir ath. or: After this certificate has been s the funeral director, page 2 should b		examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatie	nt 2 ER	/Outpatient 3	DOA Other	Nursing Home 5	Residence 6 🗸 Ott	ner: Scene	
of ng Ph uneral	<u> </u>	27. Manner of Death	28a. Date of Inju FOUND: Day,Y	ry 28l	b. Time of Injury	28c. Injury at Wo	rk? 28d. Describ	e how injury occurred		
on tendi	읥	Natural 5 Pending  Accident Investigation	D 2 0040		DUND: 505 hrs	1 Yes 2 ₩	No VICUITI OF I	louseme		
Division tal or Attendir rs after death. al Director: A	اق	3 Suicide 6 Could not t	28e Place of In			ory, office building,			Rural Route Number, City	
Division of \\ To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	4 Homicide determined		Iti-Family A	Apt.		or Town 82 East Ma	n Street Apartment 2	, Frostburg, MD	
Hosi 24 hc Fund rtely f								use(s) and manner as s		
o the ithin o the	Medical	one) 2 Medical Examiner	On the basis of exar	mination and/o	or investigation, in	my opinion, death o	occurred at the time, da	te and place, and due to	the cause(s)	
	Me	29b. Signature and title of certifier				29c. License numbe	r	29d. Date signed (M	fonth, Day, Year)	
10		( () as ( ) .	IN			O.C.M.E.		December 4, 2	010	
_	ŀ	30. Name and address of person who d	ompleted cause of d	eath (Item 23a	a)	-				
			ant Medical Exa		,	et, Baltimore, M	MD 21201			

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

OGME

32. Registrar's Signature

			Plea	ase Type or Pr						-	_	le.			
			For State Registrar	State of M	faryland / D		ment of F icate of i		ıd Ment	al Hygie <sub>Reg</sub>	401	0 411	84		
	Physici /Medic		1. Decedent's Name (First, Midd		d David 1	KOFFS	KY		M	ate of Death onth cember		3. Time of 1:10	of Death		
	Examir		4a. Facility Name (If not institution		r)	4b	. City, Town, o		eath		4c. County of				
			4900 Falstone			16	Chevy		11			tgomery			
L	Funeral Director		5. Social Security Number  579-10-5008  Usual Residence of Decedent	6. Sex 1 <b>X</b> M 2 □ F	ge (In yrs. last birt		Under 1 Year onths Days		Min. (A						
	Maryland -f show iled at	tor	10a. State 10b. County	tgomery	10c. City, Town		Chase					10d. Inside 0	City Limits		
	r 28a	Director	10e. Street and Number			1	Of. Zip Code			10g	. Citizen of W	nat Country?			
	h with	a D	4900 Falstone A	Avenue			2081	1.5			United	States			
	death	Funeral	11. Marital Status	12. Was Deceden		13. Was	Decedent of H	ispanic Origin	? (Specify Y	es or No-	14. Race	- American Indian,			
900	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Evanihar court be notified at	5	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	I ITYES GIVE	No Turu TT	1 _	s, specify Cuba Yes 2 ☐XNo	Specify:	uerto Hican	, etc.)		, White, etc. white			
21215-0036	thin 72 h ne. an "natu	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed)  College (1-4or		Decedent (Give kind life. DO I	's Usual Occup I of work done o NOT use retired	ation during most of 1)	working	16	b. Kind of Bus	iness/Industry			
21	ygien ygien er th	S		5+		Attor	ney			D	epartm	ent of Ju	stic		
pu	tal H d oth	Be	17. Father's Name (First, Middle,	, Last)				18. Mother's	Name (Firs	t, Middle, Ma	Maiden Surname)				
yla	d 2 should I th and Men 7 is marke traumatic	ပ္	Samue	el Paul Koff	sky				Ro	se Sut	in				
a		3	19a. Informant's Name/Relations			-						State, Zip Code)			
2,			Louise Koffsky	y, Wife			alstone								
Baltimore, Maryland	permit. Pages 1 am Department of Heal Important: If item 2 any Injury or other		20a. Method of Disposition  1  Surial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  King David Memorial Garden 12/08/10 Falls Church												
Balt	permit. Depart Import any Inj	21. Signature of Eureral Service Licensee  22. Name and Address of Facility  Torchinsky Hebrew Funeral Home 25% Carroll St. NW. Washington  23a. Part 1. Erier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,													
	Physician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)		Approxima Interval Be Onset and	etween									
	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequence o	of):									
68760,	ate be executed hysician and he burial-transit	ल	resulting in death) Last	Due to (or a	o (or as a consequence of):										
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	IF FEMALE:   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   1									23d. Date Mor	of delivery th Day	Year		
σ.	that ned b deta		Part II. Other significant conditi	ions contributing to death	but not resulting in	the under	lying cause giv	en in Part I.	2	3e. Did toba	cco use contri	bute to the cause of	death?		
.ds	uires n sign Id be	d b	Sick Sinus Sy	ndrome						1 □ Yes	2 🗌 No	3 Probably 4 🕅	Unknow		
00	w requir been s should	ete								4- 18/	0.415 14				
of Vital Records,	sician: The lav certificate has rector, page 2	Completed by								4a. Was an autopsy performe □Yes 2	l p	/ere autopsy findings rior to completion of eath? □Yes 2□No			
Ζij	Physician: this certific ral director, I	Be	25. Was case referred to medica examiner?	Hospital:			Oth	26. Place of	Death (Che	eck only one)					
of	Physical di	မှု	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpa 28a. Date of Ir	tient 2 ER/Ou	tpatient 3	S D DOA	4 LI Nursi			ce 6 □Othe				
n	ding I h. After funer	ig	1 Natural 5 ☐ Pendir	ng (Month, L	Day, Year)	njury	28c. Injur Worl	</td <td></td> <td>escribe now</td> <td>injury occurre</td> <td>α</td> <td></td>		escribe now	injury occurre	α			
Division	I or Attending after death. Director: After I in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could	le 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number of						r or Rural Route Nu	mber,				
	Hospita 24 hours Funeral tely filler	Medical Co	29a. Certifier  (Check only one)  1 Certifyi  2 Medical	ing Physician: To the besing Examiner: On the basis and manner:	of examination an	, death oc d/or invest	curred at the ti	me, date and popinion, death	place, and d occurred at	ue to the cau the time, date	se(s) and ma e and place, a	nner as stated. nd due to the cause	(s)		
	To the within 2 To the comple	Me	29b. Signature and title of certific	en			29c. Licens	e number		290	. Date signed	(Month, Day, Year)	-		
	15+1		> (A)	Wholes			D2	657	1		12/7	10			

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene() State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5 Day Physician/ DEC. 2010 9:30 AM Irving Norton King Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Brighton Gardens 8. Date of Birth (Month, Day, Yea FEB 29 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Hours Min. New York Director 123-16-5958 82 FEB Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Montgomery Bethesda 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 8925 Charred Oak Dr. 20817 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 To No Specify: item 27 is marked other than "natural", other traumatic event, the Medical Exar Specify.White 3 X Widowed 4 ☐ Divorced Completed Year or Dates. Korean 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Women's Clothing 5+Head of Personnel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Malvina Fishman Martin King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Karen King Simon/Daughter 8925 Charred Oak Dr., Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) lantic Crematory 12/8/2010 Glen Burnie, MD Signature of Funeral Service Thibadeau Mortuary Service, p.a. 7 Park Ave., Gaithersburg, MD 20877 nece 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Atherosclerotic Heart Disease Medical Due to (or as a consequence of) Examiner Insulin Dependent Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the buriations! Hypertension Exa Due to (or as a consequence of) Physician/Medical Heel Ulcer Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Perpheral Vascular Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementia autopsy performed To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director. After this certificate h completed filled in by the funeral director, page 2 X No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 5 Pending X Natural Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 12/6/2010 D53691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay Reddy, 3200 Tower Oaks Blvd. #110--Rockville.MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

08

Division of Vital Records, P.O. Box 68760. To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After filled in by completely

dical Examiner													
уsісіап/ме	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1												
red by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
Comple					24a. Was an autopsy performed? 1 ☐ Yes 2 ☑	death?	utopsy findings available completion of cause of s 2 \( \square \) No						
9	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)								
0	1 ☐ Yes 2. No	Hospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatient 3 0	OOA Other: 4 Nursing H	lome 5 Residence	6 ☐Other (Spe	ecify)						
ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Bb. Time of Injury M	28c. Injury at Work?	28d. Describe how in	ury occurred							
Certific	3 ☐ Suicide 4 ☐ Homicide  City or Town, State)  Suicide  City or Town, State)  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)												
edical	29a. Certifier (Check only one)  18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
2	29b. Signature and title of certifier	a Gome	2	9c. License number		mber 7, 20	, ,, ,						

PERMANENTE EXECUTAVE BLD ROCKUDIE MID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

5:23 P

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

State

Registrar

SHIFUAN

31. Date filed (Month, Day, Year)

KATSER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOSTNE

0 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Nov. 14, 2010 Prince Paul Karqbo Jr. 0800 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital Social Security Number If Under 1 Year 6. Sex If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 🛛 M 2 🗆 F 16 11777472010 Director none Yrs. Maryland Usual Residence of Decedent 28a-f shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George' Beltsville 1 🗆 Yes 2 🖂 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11427 Cherry Hill Road #104 20705 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 X Never Married 2 Married 2 X No þ 1 Yes 1 ☐ Yes 2 No Specify: Black "natural", Completed 3 🗌 Widowed 4 🗌 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) none none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Prince Paul Kargbo Sr. Vanetta Anderson 19a. Informant's Name/Relationship (Type, Print) father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20705Prince Paul Karqbo Sr./ 1 and 2 s f Health item 27 11427 Cherry Hill Road #104 Beltsville, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date cemetery, crematory or other place)
Gate of Heaven 1 X Burial 2 Cremation 3 Removal from State 11/22/2010 Silver Spring, Md 4 Donation 5 Other (Specify) a Service Licenses PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death
1 hr. 16min Physician/ Extreme prematurity disease or condition Medical resulting in death) Examine Possible pulmonary hypoplasia 1hr.16min Sequentially list conditions, if any, leading to immediate cause. Enter Underlying 100 Exami death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death Yes 2 ☐ No 9 Unknown 9 Unknown that the signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1  $\square$  Yes 2  $\Sigma$  No 3  $\square$  Probably 4  $\square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo page Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital 1 ☐ Yes 2 X No Other: ျှ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: Ai
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055515 11/14/2010 Lalega

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O. 1

Records,

Division of Vital

1500 Forest Glen Rd. Silver Spring Md 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Andrea Lotze

10 2010

31. Date filed (Month, Day, Year)

OEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 344 M 2010 Medical Facility Name (if not institution, give street and number, 4b. City, 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours 1 € M 2 □ F (Month, Day, Year) 12/23/1942 217-36-8286 Washington DC 67 Director Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director CA. Santa Cruz Santa Cruz 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 380 Lake Ave. 95062 USA 12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 XYes 2 No
If Yes, Give Vietnam
Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 Yes XX No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Attorney Legal 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Catherine Parker Joseph Michael Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alameda Ste 200 Shawn Lyons Son The San Jose, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Tycremation 3 Removal from State 4 Donation 5 Other (Specify) 12/9/2010 Glen Burnie, MD Atlantic Crematory . Signature of Funeral Service 22. Name and Address of Facility Hardesty Funeral Home, P.A. 10 Annapolis Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresshock, or heart failure. List only one cause on each line. Approximate Interv Between Onse and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown g Unknown our runeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🖂 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of 29d. Pate signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type

State

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

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2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Marshall Edwn Wolfer 1 14:48 M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 😿 M 2 🗆 F Hours (Month, Day, Year) 07/03/1942 **Director** 100-32-6407 68 NY Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits MD St. Mary's Dameron 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 16545 Saint Jeromes Neck Road 20628 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or δ 1 Never Married 2 🙀 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Completed White other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. T is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Entrepreneur Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edwin Victor Ludlow Rita Madeline Doxsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Mary Ludlow / Wife 16545 Saint Jeromes Neck Road, Dameron MD 20628 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Lee Crmatory 12/11/2010 Clinton, MD 4 Donation 5 Other (Specify) 21. Signature of Faneral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, Lisa M. Mounts 8125 Southern Md Blvd., Owings, JMD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. White By MEDINE CHAMIN Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Multiple Inuries Medical Examiner Motor vehicle accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Cervice spui tracture, empyema, rech abscess, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an Deep vin thousases, bilateral cerebellar and Jas prior to completion of cause of death?

1 Yes 2 No autopsy performed?

1 X Yes 2 \( \square\$ No brain stem herniation infarctions with 25. Was case referred to medical examiner?

1 X Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident or Attending 5 Pending s after death.

I Director: Aff
d in by the fur 1 Yes 2 No 1228 PM motor vehicle crash Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)
235 Hermonville Rd. mp 28e. Place of Injury - At home, farm, street, factory, office building, etc., (Specify) determined within 24 hours af

To the Funeral Di

completed filled in Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29d. Date signed (Month, Day, Year) NP1: 1225160609 12/6/2010 KW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 22 South Greene Street

Registrar DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

68760

Box

Records,

of Vital

Division

Fredlander

32. Registrar's Signature

Daniel

31. Date filed (Month, Day, Year)

DEC 13 2010

Bathmore, MD

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12704/2010 Lilian May Loman 6:45 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13609 Daisy Circle Hagerstown Washington Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Days Hours Yrs United Kingdom Director 240-40-6827 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No MD Charles Waldorf 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2103 Country Pines Court 20601 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 X Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Clerical Federal Government traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frank Payne Kate Painter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Randall Whitley / 7805 Arbor Way, Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 12/14/2010 Cheltenham, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Inset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Breast Cancer vears Medical Due to (or as a consequence of) Examiner Malnutrition Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit Exami or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of the 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No 5 Other (specify) Month Day detached P.O. ģ been signed be should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 Yes of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 X No Other: Daughter's ည 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 X Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Division nours after death.

neral Director: Af
illed in by the fu 2 Accident
3 Suicide
4 Homicide 1 Tyes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D68995 12/08/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) drw 1130 Opal Court, Hagerstown, MD 21740 Yong Tang, MD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NEC Registrar

DHMH 17 Rev 7/2009

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~	Funeral		5. Social Security Nu	mber 6.	Sex 7. Ag	e (In yrs. I	ast birthday)	If Unc	ersto ler 1 Year	If Under 24 Hrs	8. Date of B	rth	9 Bir	n County thplace (State or Foreign
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Ma	Jeanine Kurtyka / Daughter    Oralia K. Tette													*
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<u>m</u>	Page nent o ant: If ıry or	1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify)  Cedar Lawn Mem. Park 12-13-2010 Hagerst											erstown	,Maryland
Baltimore,	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Douglas A. Fiery Funer  1331 Eastern Blvd. N. Hagerstown, MD													
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Division of Vital Records, P.O.	ding F th. After funer	Certificate:	27. Manner of Death  1  → Natural  2  → Accident	5 Pending	28a. Date of inju (Month, Day	ry /, Year)	28b. Time of injury	М	28c. Injury work 1 🗆		28d. Describe	how inju	ry occurred	
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	e Hos 124 ho e Fune bleted f	Medical	(Check 2	Medical Exar	ysician: To the best of niner: On the basis of e rse Practioner: To the	xaminatior	and/or inves	tigation, i	n my opinio	on, death occurred	at the time, date	and place	e, and due to the	cause(s) and manner stated.
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	Physicia Medic		1. Decedent's Name (First, Middle, Last)  NGRJES LEC LEM   64		2. Date of Death Month	Day Year	3. Time of Death							
	Examin		4a Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	(a)	4c. County of Dear	th							
	Funeral Director		5. Social Security Number  6. Sex 1 DA 2 DF  7. Age (In yrs. last birthda)  7. Yrs.	Months Days Hours Min	8. Date of Birth Month, Day, Year	r) Co	thplace (State or Foreign							
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)36	after death v al", or items examiner mu	þ	11. Marital Status  1  Never Married 2  Married  12. Was Decedent Ever in U.S. Armed Forces?  1  Ses 2 No If Yes, Give	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I  1 Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:								
Baltimore, Maryland 21215-0036	ene. r than "naturithe Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) (Gine (Gine (14.4 a.5.)) (Ife.	cedent's Usual Occupation ve kind of work done during most of workin DO NOT use retired) IFO COM OIL LUMP	ng, 16b.	Kind of Business	Industry							
yland 2	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17, Father's Name (First, Middle, Last)		e (First, Middle, Maide	en Surname)	24							
, Mar				ailing Address (Street and Number or Rura A W BONIWOOD TURN	A 1 1 1	or Town, State, Zij	o Code) 735							
imore			20a. Method of Disposition  20b. Place of Dis  Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	Date 20c.	Location - City or	Town, State								
Balt	21. Signature of Fundal Servicus and Address of Facility Wiseman Function  22. Name and Address of Facility Wiseman Function  7527 Old Alexandruc Ferury Rd Clinica M													
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Division of Vital Records, P.O. Box 6876( tal or Attending Physician: The law requires that the death certificate	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy, completed filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	livery Day Year							
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To th	Voith Con		29b. Signature and title of certifie	29c. License number  £ 00 7010 7		Date signed (Mont)								
	20		30. Name and address of person who completed cause of death (Item 23a) (Type	BasilCt #200	12000	WD2	-0774							
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 🖯 🗎 U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/  $A^{\mathsf{M}}$ 2:45 2010 <u>Feiyu Lin</u> Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bethesda Health & Rehabilitation Ctr Montgomery Bethesda 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Country) China **Funeral** Days Hours 1 □ M 2 🕱 F 0370871918 Director 92 083-30-5637 Usual Residence of Decedent shov 10d. Inside City Limits 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Bethesda MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20814 5721 Grosvenor Lane . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 X Divorced Asian Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Underwriter Insurance event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev Chaiyaphruk unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5809 Grosvenor Lane, Bethesda, MD Theodore C.M. Li / son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 12/11/2010 Alexandria, Virginia 4 D Donation 5 D Other (Specify) 22. Name and Address of Facility ature of Funeral Service 7211 Lee Highway Advent Funeral & Cremation Svcs. Falls Church, Part 1. Enter the disease, or complications that caused the shock, or neart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final neumonia Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Exami Cause (Disease or linjury the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician. The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown signed by the aid be detached for 4 ☐ Pregnant a
9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed dult failure to thrive 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No this certificate has ral director, page 2: 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Be Hospital: Other: 2 **X** No 1 🗌 Yes 4 In Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending 1 🔲 Yes 2 🗆 No death. Investigation Accident within 24 hours after death

To the Funeral Director, A

completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 143121 (howar 30. Name and address of person who complete d cause of death (Item 23a) (Type, Print) Augustin 2011 (1909) Type, Minu Drine, Auritansville, MD 20866

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12706/2010 9:45  $A^M$ James Thomas Lynn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Brighton Gardens North Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral Min (Month, Day, Year) 02/27/1927 1 🔀 M 2 🗆 F Yrs. Director 275-20-0597 83 Ohio Usual Residence of Decedent ms 23a or 28a-f show must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Monroe Key Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 Sunset Cay SA ural", or items a 33037 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes If Yes, Give 2 🗌 No 1 Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White WW 11 Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company <u>Executive</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Dorothea Petersen Fred Robert Lynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sunset Cay, Key Largo, FL 33037 Joan M. Lynn 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 

Burial 2 

Cremation 3 

Removal from State 4 Donation 5 Other (Specify) 12/08/2010 Falls Church, Va National Crematory 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Lieensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Within 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician are completed filled in by the funeral director, page 2 should be detached for use as the burial-trafish. <u>Dysphagia</u> that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 👿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number M.D 2)30/32 10

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

**Division of Vital** 

14812 Physicians Lane, Suite 161 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.C.

32. Registrar's Signature

Rita Ghosh, M.D.

DEC 09 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:26 ам December Manrid Ivan Lumpkin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 13817 Mills Avenue Silver Spring If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Virginia 1 **X** M 2 □ F Months Days Hours Min. **Director** 82 228-22-9522 Usual Residence of Decedent 28a-f show 10a, State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring Maryland Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 U.S.A 13817 Mills Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No 1951þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Divorced 4 Divorced Caucasian 1952 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Iva Pearl Brizendine Manrid Quinton Lumpkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13817 Mills Avenue, Silver Spring, Maryland 20904 Beverly Jean Lumpkin - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 12/14/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Years shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of Examiner 25 Years <u>Atherosclerotic Heart Disease</u> Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No the 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 I Inknown signed by th. be d⊶ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 X Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available cate has t autopsy prior to completion of cause of death?

1 Yes 2 No After this certificate 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 🗆 Other (Specify) Hospital: 2 🗓 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) December 03, 2010 D0012121 ID 30. Name and address of person who completes cause of death (Item 23a) (Type, Print)

Registrar

State

George Sengstack, M.D.,

0.9 2010

31. Date filed (Month, Day, Year)

37 Registrar's Signature

3929 Ferrara Drive, Wheaton, Maryland 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Registra AMEND#17perFH, 12/8/10, BWW, MoCo 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year YUN CHEN December LIN Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death ROCKVILLE Examiner 4c. County of Death Ad monta Grove ventist HOSP ta omer Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2X F Days SEPT. 24, 1923 Hours Min CHINA Director 87 593-16-5363 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🛣 No MD. MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3310 N. LEISURE WORLD BLVD.#124 20906 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 XNo 1 ☐ Yes 2 XNo Specify. If Yes. Give 3

Widowed 4 □ Divorced Specify: Year or Dates ASIAN 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER HOME Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK. UNK. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHUN-LAI LEO LIN/SON 4405 FRANCES GREEN WAY, GAITHERSBURG, MD. 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKLAWN CEMETERY 12-11-10 ROCKVILLE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 3∕400091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Physician End Stage Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Line, Underlying Cause (Disease or iinjury that initiated events southing in death). Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Other (specify) Pregnant at time of death Month Day Year signed by the a d be detached f 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Facial abscess Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Encephalopath 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🖽 2 AVO 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manney of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending work?
1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) December 6,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Car Dr Rockville, MD 20850 MD Medical 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 08 2010 Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Year 06:40 M 2010 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4c. County of Death UMMC Kaltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 😾 F Director 265-92-3011 62 11/4/1948 MD ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Manchester 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4719 Watertank Road 21102 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married ☐ Yes 2x No Yes, Give Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) medical secretary hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles H. von Beren Florence von Beren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Myers, husband 4719 Watertank Rd., Manchester, Md. 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 12/4/2010 4 Donation 5 Other (Specify) Carroll Cremation Hampstead, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home M00741 panda Sem St., Hampstead, Md. 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Diverticuliti To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown has been sign 24b. Were autopsy findings available prior to completion of cause of 24a, Was an After this certificate has funeral director, page 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No ၉ 1 

✓ Inpatient 2 

ER/Outpatient 3 

DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 🔀 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year, Oliver Tannous, HD. 3/2010 WIL 1285952655 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZZ S. Green St, Baltimon, MD Oliver Tannous 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month J. Meinzer Ann 08 2010 6:00 A Medical December 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Severna Park Genesis Severna Park Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 M 2 X Days Months (Month, Day, Year Min. Indiana 87 Director 314-18-5179 July 04,1923 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Directo MD Anne Arundel Severna Park 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 24 Truck House Road 21146 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed 3 XWidowed 4 ☐ Divorced Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker/ Waitress Home/ Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any july or other traumatic once. John Evanich Josephine Jursinic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Chilla / Daughter 33 Winding Woods Way Pasadena, MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December Burial 2 Cremation 3 Removal from State Meadowlawn Memorial New Port Richey, FL Donation 5 Other (Specify) 2010 Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Highway Severna Park, MD 21146 Part 1. Enter the disease, or 1 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Imme of te Cause (Final disease or condition resulting in death) Onset and Death Physician/ ARTERIOSCIEROTIC CARDIOVASCULAR Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ğ DEM ENTIA Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No the funeral director. 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 2 100 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After work?
1 Yes 2 No 1 Natural 5 Pending injury Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JERGUBER 9, 2010 21776 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAROENA MOZIEZ RITCHIE HIGHWAY 8021 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1- State Amended item#7, WCHD, SLU, 12.16. Ortificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Дм 12 2010 Edward Howard Marshall Dec. 9:56 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 30345 Dixon Road Salisbury
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min. Hours 1**X** M 2 ☐ F Director 78 June 19. 1932 | Delaware 220-26-8816 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Evarrings rust be notified at 1 ☐Yes 2 XINO Funeral Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 30345 Dixon Road 21804 USA 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1XTYes 2 ☐ No 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: 1 ☐ Yes 2 ☑ No Specify: Completed by 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) item 27 is marked other than "nature other traumatic event, the Medical Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th manager E. I. Dupont 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward James Marshall 2 Annie Elizabeth Howard 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrell Marshall/son 751 Jacob's Mill Pond Rd, #433, Elgin, S.C. 29045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Golden 12/18/2010 | Selbyville, Delaware Acres Cem. 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD 21. Sign Jury of Funeral Service Licenses JOLLEY MEMORIAL CHAPEL 23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final artinir **Physician** Englan Carchae disease Condiamyolish disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown moulin dependent whension Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 2 11No 1 ☐Yes 2 ☐ No 1 ☐Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

18 12 W

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

State Registrar odnen

Year)

RUDNEY A. WENRICH

31. Date filed (Month Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1346

32. Registrar's Signatur

S. DIVISION ST.

15384

SALISBURY

DEC 15, 2010

MD 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 1119 M Ammie Leatha Lewis Marshall Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Wicomic *x*1115ba <u>Peninsula Regional Medical</u> f Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Age (In yrs. last birthday) Days (Month, Day, Year) 9-15-1943 1 □ M 2 🗶 F Months Min. Director 67 30-52-5338 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show traumatile event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗌 No MDWicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7060 Taft Ct, USA Apt 21804 D 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 ☐ Divorced Spec Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Retail Sales Cashier Department Stores Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Theodore Roosevelt Lewis Leatha Ammie Downing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) per nit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Karen Marshall/Daughter Rd. Apt 103, Salisbury. East MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plate) 20c. Location - City or Town, State Date 1 Burial 2 Carcanation 3 Removal from State <u>Direct Crematory, 12/14/2010 Dover, DE</u> 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lic 22. Name and Address of Facility  $917\,$  W. Isabella St Bennie Smith U Salisbury, Part 1. Enfer the see, or complications that caused the death. Do not enter the mode of dying, and ardiac oshock, or home failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat ause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an cate has autopsy To the Hospital or Attending Physician: The la within 24 hours after death.
To the Furneral Director: After this certificate h completed filled in by the funeral director, page 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗆 Certifying Nurse Practigher: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat 29d. Date signed (Month, Day, Year) 8 10 61 erson who completed ca of death tem 23a) (Type, Print) 100, E KHAN CARROLL MD SALISBURY

State

Registrar

Box 68760

P.O.

Records,

**Division of Vital** 

32 Registrar's Signature

Breun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amended # 23a per MD, RG FCHD 12/14/10
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 9 2010 11:35 PM ALBERT OWEN MERCER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick 611 West Patrick Street Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Apri. 28 Year 918 1 X M 2 D F Days Hours Director 92 Maryland 214-10-3841 Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director X 1 ☐ Yes 2 ☐ No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21.701 U.S.A. 611 West Patrick Street 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed White Year or Dates WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Insurance any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Grove Grayson H. Mercer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David H. Mercer / Son 2205 E. Palace Green Terrace, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 12/11/2010 20c. Location - City or Town, State permit. Page 1 a Department of F 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ROBERT Address of Facility & SON FUNERAL HOMES, P. A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications sa caused to shock, or heart failure. List only one cause on such line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

ANOXIC BRAIN INJURY Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ en disease or condition resulting in death) unes Medical Due to (or as a consequence of) Examiner Swigentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and I-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). nding physician a use as the burial-1 Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records. 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No Yes 2 25. Was case referred to medical of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗹 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, 4 🗌 Nursing Home Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work? 1 ☐ Yes 2 ☐ No Division s after death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the l within 2 To the l Certifying Nerse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Ye

Year)

ted cause of death (Item-23a) (Type, Print)

r's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ McCullough December 11:00 A.M Louise Marjorie Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Anne Arundel Exeter Street Churchton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🕱 F Months Min Hours 0697071923 Washington. 87 Director 579-22-7997 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2 🔀 No Anne Arundel Lothian 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 20711 A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cook Marie McWiggin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5543 Exeter Street, Churchton, MD Sharon A. Anderson, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 12-8-2010 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 20736 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Breast disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or inijur) and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Pregnant at time of death 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to autopsy performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 - Nursing Home 5 - Residence 6 X Other Specify hter's home မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 🗷 Natural 2 🗆 No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) ٩ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) suite 212.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 10, 2010 5:00 A M Mebane Audrev Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Ft. Washington 522 Kisconko Turn If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Numbe 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** 03/23/1923 577-24-1760 1 M 2 X X 87 Washington, DC **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10a. State Director Ft. Washington 1 Yes 2 X No Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20744 9705 Caltor Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. Yes 2 X No Yes, Give 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. **Black** Specify: 3XXWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Internal Revenue Serv. Secretary 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carter Virginia Brannum Ralph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 9705 Caltor Lane Ft. Washington, MD 19a. Informant's Name/Relationship (Type, Print) 20744 Diane Savoy / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Lincoln Mem. Cem. 12/20/2010 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses George P. Kalas Funeral Home PA Rd. Oxon Hill, Maryland 20745 6160 Oxon Hill 23a. Part Denter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 1 Yes XX No the 9 Unknown detached P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No or Attending Physician: The law has certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Assisted Living Other: 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directorial directory. 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: (Month, Day, Year) X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ivan Zama MD 9200 Basil Court #200 Largo, Maryland 20774 31. Date filed (Month, Day, Year, 32. Registrar's Signature State park **DEC 1 4 2010** Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State	of Mai	ryland	-		nt of H <i>te of L</i>			ental Hy	giene Reg. No.		41205		
7		13	1. Decedent's Name (	First, Middle, L	ast)	_							2. Date of De	Dav	Year	3. Time of Death		
	Physici: /Medic		Josephine	e Muel	ler								12/8/2	010		6:15 P M		
95	Examin	- 16	4a. Facility Name (If no	ot institution, g	ive street and n	umber)			4b. City	, Town, or	Location	of Death			County of Dea	th		
1			9403 Whit			7 4-0	/lm las	A brindbalass)		lin er 1 Year	If Under	24 Hrs	Worcester  8. Date of Birth  9. Birthplace (State o.					
и	Funeral		5. Social Security Num		Sex 1 □ M 2 🛣 F	7. Age	(in yrs. ias	st birthday). Yrs.	Months		Hours	Min.	/14/39	y, Year)	E1	thplace <i>(State or Foreign</i> ountry) ng Land		
	Director		135-32-31 Usual Residence of Do			, 1						r	,, ,, ,,					
	yland now at		10a. State 1	0b. County				Town or Lo	cation							10d. Inside City Limits		
	a-f sh	ctor	MD V	Worcest	er		Ber	lin								1 □Yes 🙊 □ No		
	or 28	Director	10e. Street and Numb							ip Code				- 5	izen of What C	ountry?		
	ath w	la	9403 Whit	te Tail						811		1-1-0 (0	aif. Van av Ni	USA	14. Race - Am	erican Indian		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married  3 ☐ Widowed 42		12. Was De Armed F 1 ☐ Yes If Yes, 0 Year or	Forces? s 2 <b>⊠</b> No Give			was Dec f Yes, sp 1 □ Yes		spanic Oi n, Mexica Specify		cify Yes or No Rican, etc.)	)-	Black, Wh	ite, etc.		
Maryland 21215-0036	2 hou natura ical E	Completed	1.	5. Decedent's	Education grade completed	4)		16a. Deced	dent's Us	ual Occup	ation	st of workir	na	16b. K	ind of Business	s/Industry		
215	thin 7 e. an "r	ple	Elementary/Second			(1-4or 5+	)					st of workir		Vota	ad nowi	a <b>n</b>		
21	ed wi ygien ier th t, the	S	12					Veter	inar	lan i			1 (First, Middle		rinari.	all		
pu	be fill tal H id oth even	Be	17. Father's Name (Fi		st)								Editl		•			
уlа	ould Men narke	은	George H		(Time Print)		1	10b Mailin	a Addra	es (Straat						Zin Code)		
Na	12 st h and 7 is n traun		19a. Informant's Name/Relationship (Type. Print)  Michael Mueller (son)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town  241 Powell Circle, Berlin, MD 21811											_				
e,	1 and Healt em 2		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date 20c. Location										Oc. Location - City or Town, State					
Jou	ages nt of t; if it											shoro.	DE					
Baltimore,	artme artme ortan injur		1   Burial 2x Cremation 3   Removal from State   4   Donation 5   Other (Specify)   First State Crematory 12/9/2010   Millsbor   21. Signal 1   Fun all Service Licensee   22. Name and Address of Facility   The Burbage Funer															
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	1		23a. Pan1. Enter the shock, or heart	lisease, or co	mplications In	caused t	the death.	Do not ent								Approximate Interval Between		
	Physician		Immediate Cause (Fi				51791	70	Pm	VCRE	27477	C	CANC	EX	2	Onset and Death		
	/Medical resulting in death)  Due to (or as a consequence of):																	
83	Examiner	L	Sequentially list conditions, if any leading to immediate  Due to (or as a consequence of):															
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.													ļ		
	xecut and Il-tran	Examiner	that initiated events resulting in death) La	st	c	to (or as a	conseque	ence of):										
8760,	icate be executed physician and s the burial-transit	a E																
687	ficate physis the	edical			d													
.O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?		e birth :	of pregnar 2  Fetal time of de	death 3[	⊒Ectopic ⊒ Other	pregnancy (specify) _	/				23d. Date of d Month	elivery Day Year		
Δ.	w requires that the de been signed by the should be detached	H.	Part II. Other signific	ant condition	s contributing to	death bu	t not resul	ting in the u	nderlying	cause giv	en in Parl	t I.	23e. Did	tobacco	use contribute	to the cause of death?		
rds	quires n sign ald be	d b		:									1 🗆	Yes 2	2□ No 3□	Probably 4 Unknown		
S		ete											24a. Wa		24b. Were	autopsy findings available completion of cause of		
Re	The law ate has b	E O											per 1□ Yes	opsy formed? 2 X N	death 1 □ Y	?		
ta		a	25. Was case referre	ed to medical							26. Pla	ce of Death	(Check only					
<b>r</b> <	ys dir	To B	examiner? 1 □ Yes 2 <b>∑</b> N	lo	Hospital: 1 [	☐ Inpatie	nt 2 🗆 E	R/Outpatie	nt 3□	DOA Oth	er: 4 □ 1	Nursing Ho	me 5 Re	sidence	6 □Other (S	pecify)		
0 1	ding Ph .r. After th funeral		27. Manner of Death	5 Pending	28a. Da (M	te of Injur		28b. Time o Injury		28c. Inju			28d. Describe	e how inju	iry occurred			
<u> </u>	Attending r death. ector: After by the fune	satic	2 ☐ Accident	investiga 6 □ Could no					М		Yes 2							
Division or Vital Records,	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determin	200, F18	ace of inju ilding, etc	ry - At hor . <i>(Specify</i>	ne, farm, st )	reet, fact	ory, office			28f. Location City or T	(Street a own, Stat	na Number or te)	Rural Route Number,		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Ce	29a. Certifier 1	Certifying	Physician: To	the best o	of my knov	vledae, deat	th occurr	ed at the ti	me, date	and place	and due to th	e cause(	s) and manner	as stated.		
	24 hc 24 hc Fun etely i	edical	(Check only one)	Medical E	xaminer: On the	e basis <del>ef</del> anner sta	examinat	ion and/or ir	nvestigat	ion, in my	opinion, d	leath occur	red at the tim	e, date a	nd place, and o	lue to the cause(s)		
	ro the vithin 2 ro the comple	Mec	29b. Signature and to	itie of certifier				7		29c. Licens	se numbe	r		29d. D	ate signed (Mo	onth, Day, Year)		
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		1	30. Name and addre	ss of person w	ho completed ca	ause of de	eath (Item	23a) (Type	(Print)	111	717	~~	201	50	12.11	Bonn		
	6.	F.T	Emuin	U Cos	DAN E	DA	-in	1	051	70	4)	(Z)	1410	1/1	100	0)121		
		ate	31. Date filed (Month	h, Day, Year)	) 2010 <sup>32</sup>	. Registra	ır's Signat	ure	back	1					1000	2010 BENIN 2218/1		
	Reaist	rar		THE LANG	ICUIU	1. Congrada	and the same of	1 11										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 41206 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4<sup>Day</sup> Dec Physician/ 2010 June B. McVeigh 11:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carriage Hill Nursing Home Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Yea 1 M 2 X F Days Hours Min. Illinois **Director** 347-12-0638 1924 Nov Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director District 1 X Yes 2 No of Columbia Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 5420 Connecticut Ave. NW #422 20015 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Yes 2 No Specify: Caucasian permit. Page 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event, the Medical Exponen. 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Journalist <u>News Media</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Bailey Marie Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta E. Bedlington, Daughter 5611 Forest Place, Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State Loudon Park Crematory 12/9/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M01102 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ Chronic Obstructive Pulmonary Disease Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Pransit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a lor use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Day 5 Other (specify) Month Year Pregnant at time of death sate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown <u>Atrial Fibrillation</u> 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Osteoporosis within 24 hours after death.

To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed' 1 ☐ Yes 2 🔀 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific D355 2010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Ave. #305 Bethesda, MD 20814 J. Miller, M.D. Susan 31. Date filed (Month, Day, Year) Registrar's Signa State OEC 09 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 5, Physician/ Vincent Anthony Mercurio 5:20 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Birthpia Country) NY **Funeral** 1**X** M 2 □ F Months (Month, Day, Yea C. 6, 1939 **Director** 077-30-6602 70 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No Montgomery Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4639 Dustin Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. Completed by 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify.White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Realtor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gioacchino Mercurio Florence Argentiero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Mercurio/Wife 4639 Dustin Road, Burtonsville, MD 20866 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place
St. Mary of the Mills
Cemetery 1X Burial 2 Cremation 3 Removal from State Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Prostate Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 2 No Hnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 1 Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 24 No Other: 1 Yes 욘 4 🗔 Mursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident
Suicide
Homicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2 29d, Date signed (Month, Day, Year) 12-6-10 D0069829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltemone M D Suite 203 NAQUI 31. Date filed (Month, Day, Year) State 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 4 208 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Richard Culling Manning 2010 3:50 P Medical December 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 204 Indian Spring Drive Silver Spring Montgomery Social Security Number 8. Date of Birth Birthplace (State or Foreign Country)
 Chio Funeral Months 1 🔀 M 2 🗆 F Days Hours Min. April 7, 287-22-2430 83 **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 204 Indian Spring Drive 10g. Citizen of What Country? 20901 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No. 1950-1952 Black, White, etc. þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer Transportation Engineering permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Francis Manning Margarethe Henriette Kulling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Marie Manning / Wife 204 Indian Spring Drive, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1x Burial 2 Cremation 3 Removal from State Parklawn Memorial Park 4 Donation 5 Other (Specify) December 13, 2010 Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901 Mg 503 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Ischemia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) certificate be executed Hypercholesterolemia Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 Other (specify) 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Records, Completed 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 🛚 No 1 Yes 2X No Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** B B 26. Place of Death (Check only one) Hospital 1 Tes 2 🔀 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 🖫 Residence 6 🗆 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 🔀 Natural 5 Pending 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, Gary St. Miller MD 13325 December 7, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cary H. Miller, MD 2440 M Street NW., Ste. 810, Washington, DC 20037 31. Date filed (Month, Day, Year) Registrar's Signa Registrar

10-09311		Please Ty	pe or Print i	n Black I	ndelible In	k. Ens	sure	All Copie	es Are L	.egible.	201	0 6120	
Juan Jose Macar		1- For State	ate of Maryl		ertificate of		and	Mental H	ygiene	Dog No	(m /c' )	7 1 1 10	
Physicia	n/	Registrar 1. Decedent's Name (First, Midd	le,Last)						2. Date of D	Reg. No. Death Day	Year	3. Time of Death	
Medical Examin	er	Juan Jose			Maldona			antina of Dontl	Decemi	per 4, 201	Ounty of De	0710 hrs	
Some of		4a. Facility Name (if not institution University Specialty H		umber)	4	Baltimo		ocation of Deatl	1	40. (	County of Dea	aui	
Funeral		5. Social Security Number		of Birth (MM/DD/YYYY) 9. Birthplace (State or									
Director		none	1 <sup>™</sup> M 2□F	27	Yrs.	Months	Days	Hours Mir	1/2	4/198	3 (	Watemala	
any	ŀ	Usual Residence of Decedent  10a. State 10b. County			y, Town or Location	on						10d. Inside City Limits	
<b>.</b> .	_	MD Card	oline	Ma	rydel							1 Yes 2 X No	
Maryla 28x-f	Director	10e. Street and Number		<b>L</b>		10f. Zip Co				_	en of What Co		
death with the Maryland nr items 23a or 28a-f show must be notified at once,		2904 Barcla					649		'/ W		uatem	erican Indian, Black,	
eath wi	Funeral	11. Marital Status  1 Never Married 2 M	arried Armed F	cedent Ever in l forces? 2 X No				anic Origin? ( S Mexican, Puerto	Rican, etc.)		White, etc.		
after d	Dy F	3 Widowed 4 Div	orced If Yes, Give Yes or Dates:		1 X	Yes 2	No	specify: Gu	atema	lan s	Specity.		
hours hatur Exam		15. Decedent's Education (Spe			16a. Decedent during mo			n (Give kind of O NOT use ret			nd of Busines		
336 thin 72 ne. than '	Completed	Elementary/Secondary (0-12)	College (	1-4 0( 5+)	Resta	auran	ıt v	vork			Resta	urant	
215-0036 be filed within 7 that Hygiene risked other than ent, the Medica	ပ်	17. Father's Name (First, Middle, Victor Manu		rio Br	270		18	.Mother's Name	e (First, Middl	e, Maiden S	urname)	donado	
2121 Mental Mental Marke C event,	To Be	19a. Informant's Name/Relations				Address (	Street a	and Number or				donado- vasquez	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ar items 23a or 28a-f shu injury nr nither traumatic event, the Medical Examiner must be notified at once		Victor Manue		io- donado	-							1d 21663	
ore, I		20a. Method of Disposition	a 3 🗓 Removal fi	20b.	Place of Disposit crematory or othe NTON				Date / 16 / 2		san N	or Town, State Marcos, emala	
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Ball permit Depar Impo	J	21. Signa of Funeral Service	114		PH 924	TETP	D.F	KINALD	I FUN	ERAL ilver	SERVI	CE,P.A. ing,Md2091	
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/Medical Examiner	8	Immediate Cause (Final disease	a. Multiple Inj									Death	
E BOOK		or condition resulting in death)	Due to (or as a	a consequence	of):								
	ne	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause											
b =	Examiner	(Disease or injury that initiated events resulting in death) Last	С.	a consequence	of):								
			d	1 nor .	me g912	2 7 1	1					<del></del>	
50, te be ex tysiciar sysiciar burial	ledical	UNPENDED  IF FEMALE:		outcome of pre			1 4			23d	Date of delive	erv	
687( ertifica ding ph	an/N	23b. Was decedent pregnant in the past 12 months?	ne 1 Live I	oirth	2 Feta	al death	3	Ectopic pregna	ancy		lonth	Day Year	
Box 68760, a death certificate but the attending physic ed for use as the bur	Physician/M	1 Yes 2 No 9 Uni	known 9 Unkn	nant at time of d own	oeatri 5 Oth	er (Specify	)						
P.O. Es that the	호 문	Part II. Other significant condit	ions contributing t	o death but not	resulting in the ur	iderlying ca	use giv	en in Part I.				to the cause of death?	
n of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execut. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transmission and control of the									1` 24a. W			obably 4  Unknown  autopsy findings available	
Division of Vital Records, tal nr Attending Physician: The law requir as after death.  **I Director: After this certificate has been s lied in by the funeral director, page 2 should	ompleted								au	topsy rformed?		completion of cause of	
Recificate	ပေ	25. Was case referred to medica				26.1	Place of	f Death (Check		s 2 🗹 No	1	Yes 2 No	
Vital ysiciar his cert	o Be	examiner? 1 ✓ Yes 2 No	Lleanitel: -	Inpatient 2	ER/Outpatient		In	<u> </u>	ng Home 5	Residence	ce 6 Oth	ner:	
n of ding Ph.	Ë	27. Manner of Death	28a. Date	of Injury Day Year)	28b. Time of In	· ·	_ :	at Work?		nvolved it		hicle accident	
Divisior Divisior Sopital or Attend hours after death noral Director: y filled in by the	cation	2 Accident Inves	stigation 280 Plac		home, farm, street			s 2 🗸 No	28f Location	n (Street and	Number or I	Rural Route Number, City	
Divi	팋		d not be	Street	none, ram, sacci	, lactory, or	noo ban	ding, oto.		i, State)		talai Koato Kambol, Oky	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executivitin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the finneral director, page 2 should be detached for use as the burial - try	Oŀ	29a, Certifier 1 Certifying P	hysician: To the be										
To the within To the complex	Medical	one) 2 Medical Exa 29b. Signature and title of certifie	miner: On the basis and manner s		and/or investigation		icense r		at the time, da			fine cause(s)	
4		201. Signature and the or certific	1 1	-	1		D.C.M.		ME		mber 8, 2		
	-	3. Name and address of person	who completed cau	se of death (Iter	m 23a)					1			
		Theodore M. King, Jr.	, MD. Assista	ant Medical		111 Penr	Stre	et, Baltimor	e, MD 212	.01			
Sta Registr	ite ar	31. Date filed (Month, Day, Year)	2010 32 R	egistrar's Signa	J. Jan	S.							

10-09568 Agatha Marks

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 1 State of Maryland / Department of Health and Mental Hygiene

January 1	1- For State Registrar	or iviaryland / L	Certificate of			eg. No.		
Physician/ Medical Examine	Decedent's Name (First, Middle, La		1-1-6		Date of Deat     Month	h Day Year	3. Time of Death	
Medical Examine	4a. Facility Name (if not institution, g	atha Kay Mive street and number)		b. City, Town, or Location	December of Death	12, 2010 4c. County of Dea		
× ./	Holy Cross Hospital			Silver Spring		Montgomery		
Funeral Director	5. Social Security Number 6 1	Sex 7. Age (II	n yrs. last birthday)  39 Yrs.	If Under 1 Year If Under Months Days Hours			tirthplace (State or Foreign country)  Maryland	
v any	10a. State 10b. County	100	c. City, Town or Location	n	-		10d. Inside City Limits	
-f shov	Maryland Monte	omery			Spring		1 <b>X</b> Yes 2 No	
the Maryland as on 28a-f sh iffied at once	10e. Street and Number	msburg Drive		10f. Zip Code <b>20901</b>		g. Citizen of What Co	S.A.	
		12. Was Decedent Eve	er in U.S. 13, Was	Decedent of Hispanic Orig	gin? ( Specify Yes or No-	14. Race - Ame	erican Indian, Black,	
sr death with or items 23 Emust be no	1 X Never Married 2 Marrie	d Affiled Forces?  1 Yes 2 X d If Yes, Give Year	No	s, specify Cuban, Mexican		White, etc.	Causatian	
turs after amine	15 Decadest's Education (Specify	or Dates:	eted) 16a. Decedent	Yes 2 X No specify: s Usual Occupation (Give	kind of work done	Specify: 16b. Kind of Business	Caucasian s/Industry	
6 72 ho an "na ical Ex	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working life. DO NOT	use retired)			
5-0036 ed within 72 hour tygiene. other than "natt the Medical Exar Completed	12 17. Father's Name (First, Middle, Las	t)		Caregiver 18 Mother	's Name (First, Middle, M		ild Care	
21215-0036 21215-0036 and be filed within 7 Mental Hygiene. marked other than it event, the Medica FO BE COMPIE		am Marks						
Should and Me 7 is ma matic ev		2		Address (Street and Num		•		
ore, MD s: l and 2 sho of Health and If item 27 is her traumati	Kathryn Marks, 20a. Method of Disposition		20b. Place of Disposit	illiams burg on (Name of cemetery,	Date Date	20c. Location - City of		
Baltimore, M Searnit. Pages I and 2 Department of Health Important: If item 2 injury or other trans	1 Burial 2 X Cremation 3 4 Donation 5 Other Specification 5	_	crematory or other	n Crematory	12/21/2010	Brentwood	l Maruland	
Baltimo Permit. Page Department of Important: injury or ott	21. Signature Fun ral Service Lice		22. Na	me and Address of Facility	Hines-Rinal	di Funeral	2 Home, Inc.	
Physician	23a. Part Enter the disease, or com	plications that caused the	41 118	00 New Hamps	hire Ave., .	Silver Spr	ing, MD 2090 Approximate Interval	
/Medical	failure. List only one cause on a Immediate Cause (Final disease or condition resulting in death)	ach line. Hypertens	sive Cardio	vascular Dis			Between Onset and Death	
_	Sequentially list conditions,							
ted Insit Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conseque	ence of):					
760, icate be executed physician and the burial - transit	events resulting in death) Last							
760, cate be executed physician and he burial - trans'	■ UNPENDED	AMENDED 23a,	pt.II,27 p	er me g911 1	-28-11 vt			
D.O. Box 6876 that the death certificate ned by the attending phy deached for use as the 1 by Physician/M	IF FEMALE:  □3b. Was decedent pregnant in the past 12 months?  1 Yes 2 ✓ No 9 Unknow	23c. If yes, outcome of 1 Live birth 4 Pregnant at time	2 Feta	I death 3 Ectopic	pregnancy	23d. Date of delive Month	ry Day Year	
by the sched fr	Part II. Other significant conditions	9 Olikilown	t not resulting in the un	derlying cause given in Pa	rt I. 23e, Did tob	pacco use contribute to	the cause of death?	
i, P.C ires that signed I be deta	Obesity Asth		•			2 No 3 Pro	obably 4 Unknown	
Vital Records, section: The law requires in sertificate has been significate, page 2 should be Be Completed					24a. Was a autops		utopsy findings available completion of cause of	
Reco The law icate has page 2 si					perform 1 ✓ Yes 2		'es 2 No	
ital Rediction: The scertificate rector, page	25. Was case referred to medical examiner?	Hospital:	2 Z ER/Outpatient	26.Place of Death		Residence 6 Othe		
iof Viriog Physical Officers of the Control of the		28a. Date of Injury (Month, Day, Year)	28b. Time of Inj			ow injury occurred	at .	
ion treodic feath. rtor: A	1 X Natural 5 Pending 2 Accident Investigat			1 Yes 2	No			
Division of Vital Records, P.O. pital or Atteoding Physician: The law requires that the nours after death.  neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deace Certification: To Be Completed by F	3 Suicide 6 Could not determine	be [	- At home, farm, street,	factory, office building, etc	c. 28f. Location (St or Town, Sta		ural Route Number, City	
Division of Vital Records, P.O. Box 687  To the Hospital or Atteoding Physiciao: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending a completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician!		ian: To the best of my known of the basis of examination and manner stated.						
M S F 5	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mo		
	20 Marche	and	(Hom 22-)	O.C.M.E.		December 13, 2	010	
	30. Name and address of person who Laron Locke MD. Assis	tant Medical Exami		Street, Baltimore, MI	D 21201			
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature 6					

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ise Type or F							_		_		
	State of Maryland / Department of Health and Mental Hygiene 2   1   2    1 - State Registrar  Certificate of Death  Reg. No.													4   2	
		Registrar		( 4)			Cert	ificate c	of D	eath	T	Reg. N	No.		
Physicia	n/	1. Decedent's Name			N 1						2. Date of De		Day 20	010 0	3. Time of Death 9:50 P. M
Medic			bert	Alan give street and number	Neel	У		4h City Tow	vn or	Location of Death		December 7 2010 9:50  4c. County of Death			
Examin	er	7543 I S		<b>9</b>	/					ake Beacl					
Funeral		5. Social Security N		6. Sex 1 X M 2 □ F	Age (In yrs.	ast birth		If Under 1 Y		If Under 24 Hrs. Hours Min.	8. Date of Bir	8. Date of Birth 9. Bir			hplace (State or Foreign
Director		216-94-5 Usual Residence of		T MAIN 2 LIF	46	Υ	rs.	INIONICIO D	.u,o	Tiodio IVIIII.	05-24-	196	4	Vi	rginia
show at	or	10a. State	10b. County		10c. Ci	ty, Town	or Loca	ation							10d. Inside City Limits
/laryla 8a-f s tified	rect	MD	Calve	ert				Chesa	npea	ake Beac	h				1 🎇 Yes 2 □ No
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th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	7543 I S	treet					<del></del>	)732				USA		
r deat or iter iner		<ul><li>11. Marital Status</li><li>1 \( \sum \) Never Marri</li></ul>	ent Ever in U. es?   X No	S.	13. Wa	as Decedent Yes, specify (	of His Cubar	spanic Orlgin? (Sp n, Mexican, Puerto	ecify Yes or No- o Rican, etc.)			e - Ame ck, White	rican Indian, e, etc.		
s afte ral", c Exar	ed by	3 Widowed		If Yes, Give			1 [	☐ Yes 2 🔀	No	Specify:			Specify	· wh	nite
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thin 72 ne. than '	om	Elementary/Seco	onday (0-12)	College (1-4	or 5+)	Ι. ′	life. DO	NOT use ret	tired)				onat	~c+	i on
ed wit Hygie other ent, th	Be C												.1011		
be fillental	To	_ `	Albert	Neelv						Ruth				sard	
should be flied within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 25a or 28a-f sho is amatic event, the Medical Examiner must be notified at		19a. Informant's Na				19b.	Mailing	Address (St.	treet a	and Number or Ru					
nd 2 s ealth a m 27 i				Ly, spouse		75	43	I Stre	eet	, Chesap	eake Bea	ach,	MD	207	32
relartofH tofH fite or oth		20a. Method of Disp 1 🔀 Burial 2		3 Removal from S	tate (	cemetery	y, crema	ition <i>(Name</i> o atory or other	r place		Date	20c.	Location -	- City or	Town, State
permit. Page 1 and 2 should be filed within 72 hours after death v Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once.		4 Donation			So	. Me				ens 12-1			unkir		
permi Depar Impo any ir		21. Signature of Fu	Promote L	R. ale	~					s of Facility R					20736
		23a. Part 1. Enter t	the disease, or	complications that ca	used the dea	th. Do no							<del>5- y</del>		Approximate Interval Between
Physician/		Immediate Cause (	(Final	only one cause on each	- 67 G	(	60	(2/							Onset and Death
Medical Examiner		resulting in death)		Due to (or	as a consec			- 1		1					
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ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury  Choung () bC+Cuchei Pularia Pularia  Due to (or as a consequence of):  Choung () bC+Cuchei Pularia Pularia  Disease or linjury													
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ath cel attendi for use	ian/	23b. Was decedent in the past 12	months?		me of pregnanth 2  Fet Int at time of	al death		Ectopic preg		у				ate of de onth	livery Day Ye <i>a</i> r
the a	ysid	1  Yes 2  Dunknown		9 Unkno		ueaui	J L	Other (apoch	19/					_	
that the ned by a deta	by PI	Part II. Other signif	licant condition	ons contributing to dea	th but not re	sulting in	the un	derlying caus	se giv	en in Part I.	23e. Did 1	tobacco	o use cont	ribute to	the cause of death?
quires en sigi ruld be				w'		_					12	Yes	2 🗌 No	3 🗆 P	robably 4 Unknown
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The cate h								<del></del>			1 \(\sum \) Yes	ormed?		death?	2 🗆 No
sician certifi rector	Ве	25. Was case referrence examiner?  1  Yes 2	red to medical	Hospital:		1			Othe	ace of Death (Che		•			
g Phys ar this eral di	e: To	27. Manner of Deatl		28a. Date of	patient 2 I	28b. Ti	ime of	28c.	Injury	/ at	lome 5 Resi				ify)
anding sath. rr: Afte	ficat	1 Natural 2 Accident	5 Pendir	gation	Day, Year)	l in	ijury		work	? Yes 2 □ No					
r Atte ter de irecto	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could determ	ined 28e. Place o	Injury - At h		m, stree	et, factory, of	ffice		28f. Location ( City or To			er or Ru	ral Route Number,
pital o		00- 0-15- 4		Discription To the hear	A a f an . I a a		looth on	an ward at the	time	-data and place	and due to the er		and mann	or as st	atad
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2	Medical E	Physician: To the best examiner: On the basis Nurse Practioner: To	of examination	n and/or	investig	gation, in my	opinio	n, death occurred	at the time, date	and pla	ice, and du	e to the	cause(s) and manner stated.
To the To the Within To the Comp	2	29b. Signature and		1 ~		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Jago, ac			number	17			1114	h, Day, Year)
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7 10		Manoj 31. Date filed (Mont	Mathur,		Hosp:		Rd	., Ste	2. (	305, Pri	nce Fred	deri	ick.	MD 2	.0678
Stat Registra		DEC 1		Ja . Reg	potrar s Signa	aut a	a made								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Registrar 28a-f, 23a(b) per/F, 12/10/10, PW, M-Co. Registrar 28a-f, 23a(b) per/F, 12/10/10, PW, M-Co. Registrar 28a-f, 23a(b) per/F, 12/10/10, PW, M-Co. Registrar 29a(b) per/F, 1 Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 4:30a M Obiechina NOV.8,2010 Emmanuel N. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Examiner 14125 Parker Farm Way Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign County) iqeria 6. Sex 1 AM 2 □ F 8 Date of Birth Funeral Days 69912 By 1=933 77 534-68-6172 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring Md 1 ☐ Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 14125 Parker Farm Way 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Harvard University Professor of English Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Udenweze Azubuike Envibuaku Obiechina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\,20906$ Maria Obiechina/Wife Parker Farm Way Silver Spring, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/6/2011 Nkpor, Nigeria Cemetery 21. Signature uneral Service Lice PHTLTPddD: TWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE PULMONARY BILKTERAL THROMBOSIS Physician MASSINE disease or condition Medical resulting in death) Examiner CORONARY TIMOMBOSIS OF LAFT CIRCUMPLEX AT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ( / / ALL 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NRPITTITIAIA - Sie Defor block necessialy Pacemaker 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of +TN 24a. Was an autopsy performed? X Yes 1 X Yes 2 ☐ No 2 -- No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Yes 2 🔀 No ျှ 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pendina work? Accident Investigation MA 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. i ocation (Street and Number or Rural Route Number. determined building, etc. (Specify) City or Town, State) MIN Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Christian Nwankwo Jr. M.D.

2010

09

DHMH 17 Rev 7/2009

Registrar

MD

V

PHYSICIAN

7411 Riggs Rd.#404 Hyattsville, Md20783

29d. Date signed (Month, Day, Year)

December 8,2010

29c. License number

144239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 Year Charles Carson Parker Sr. 10:32 PM 36 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO ALI J BURY CASTAL HOSPICE AT THE LAKE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days 219-56-7803 1 X M 2 D F Hours Min 01/19/1952 58 Maryland **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f 1 Yes 2 X No Maryland Wicomico Pittsville 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertall Hygiene. In Apportant I fire I is marked other than "natural", or items 23a or involvant I fire I is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 21850 USA 35730 Henny Penny Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc. 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates. þ Baltimore, Maryland 21275-0036 Ärmy 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Wicomico County Youth Elementary/Seconday (0-12) Coîlege (1-4 or 5+) + Civic Center assistant stage manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Ellen Carson 0 Isaac William Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6517 Bass Lane, Milton, FL 32570 Richard Klempke/executor 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12/9/2010 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 21 Sig. ature of Fun al Service Licensee Holloway Fufferal Home Professional Association avid to 501 Snow Hill Rd., Salisbury, MD 21804 Domprow 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LIVER CARCINON Physician/ disease or condition resulting in death) MALICA NAN Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consucuence of or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 4 Pregnant Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ NO 24a. Was an Jas autopsy certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/<del>1</del>0 မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending injury death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier (Check only one 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) 6HULAN 1.0 130 x SATYBURY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month December Day Physician/ 12 2010 245 PM Raymond David Palmer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F october 4,1936 Months Hours Maryland Director 74 217-32-5991 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 🗆 Yes 2 🗓 No Maryland Washington Williamsport 10g. Citizen of What Country? 10f. Zip Code or items 23a or 10e. Street and Number Funeral USA 21795 10756 Apple Tree Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Forces?

X Yes 2 \( \sigma\) No 1959-1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced White 1961 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunications <u>Installer Technician</u> Be traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Thelma Amelia Young Van Dorin Palmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10756 Apple Tree Lane Williamsport, Maryland 21795 Janet Palmer - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of I Important: If ite any injury or of cemetery, crematory or other place) 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State Hagerstown Crematory |Dec.17,2010 Hagerstown, Maryland 4 Donation 5 Other (Specify) Osborned Funeral Home, P.A. Euneral Service 425 S. Conococheague St.Williamsport, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final RESPIRATORY Physician ACUTE disease or condition resulting in death) Medical Due to (or as a consequence of): <sup>4</sup>Examiner PNE Y MON 14 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): sician and burial-transit LARYNGEAL HISTORY OF or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy death? 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 10 Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred s after death. Certificate: injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my principle death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier A212 MOHAMMEU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Campus Rd. Hageistown MO 21742 AZIZMO 5H12+ 32. Registrar's Signature State 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 recember Angelica Perez Medical Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ENIER HARLE DICAL LATA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, You June 19 9. Birthplace (State or Foreign Country)
Chile Age (In yrs. last birthday) 5. Social Security Numbe **Funeral** 1 □ M 2 🛣 F Months Hours 67 Director 579-78-9390 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director items 23a or 28a-f s ner must be notified La Plata MD Charles 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1311 Redwood Circle 20646 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married "natural", or Maryland 21215-0036 Chilean 1 ☐ Yes 2 X No Specify. Completed 3 XWidowed 4 Divorced Year or Dates is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Retail Department Store Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Antonio Quiroga Luz Jerez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21212 88 Murdock Road, Baltimore, MD Cynthia Welsh/Daughter item 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Brinsfield-Echols 12/6/2010 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Janeyal Service Licenses M01458 AREHART-ECHOLS FUNERAL HOME, P.A. 20646 La St Mary's Plata. ATTA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequen To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Yes 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 1001 1 🗌 Yes 2 🗆 No Be ( Was case referred examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 မ 1 Yes 1 npatient 2 🗆 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27 Manu er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the pest of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chec only ( Certifying Nurse Pract noner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signa 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chon egistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 11 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** David Harry Pyrtle December 2010 12:40 P <sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fort Washington Hospital Fort Washington Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/28/1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours NXM 2 F 82 242-42-8800 Director North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2√XNo Directo Ft. Washington Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 404 Kerby Hill Road 20744 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1949-11. Marital Status Black, White, etc. XXYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 53 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White \$ 3√XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Tobacco Co. 11th aith and Mental Hygie 27 is marked other I r traumatic event, th other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rufus Harry Pyrtle Josephine C. Heimbaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Sandra L. Pyrtle / Daughter 9006 Ft. Craig Drive Burke, Virginia 22015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 12/28/2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland Maryland Vet. Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signature of uneral Service Licenses 6160 Oxon Hill Rd., Ōxon Hill, MD 20745 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) therosclerotic Disease Coronary **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Dulmonaru per tension 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D46741 2010 December MD 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEEPAK SACHDEVA MD 11711 Livingston Rd., Ft. Washington, MD 20744

Registrar

State

D. park

32. Registrar's Signature

DHMH 17 Rev 1/2001
ORIGINAL

31. Date filed (Month, Day, Year)

**DEC 1 4 2010** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2010 Parker 12:50 AM Beatrice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Ft. Washington 9544 Ft. Foote Road If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2XX 429-46-3236 80 10077471930 Arkansas Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 1 ☐ Yes 2xx No Prince George's Ft. Washington Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9544 Ft. Foote Road 20744 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. White Specify: "natural" 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetologist Beauty of Health and Mental Hygie If item 27 is marked other in other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Lowell Lee Barnett Rosa Lee Hodges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Parker / Husband 9544 Ft. Foote Road Ft. Washington, MD Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arlington Nat. Cem. 12/28/2010 | Arlington. Virginia 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature Imperal Seprine Licersee 6160 Oxon Hill Rd. Öxon Hill, Maryland 20745 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. shock, or heart fail. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to lor as a consequence of cause. Enter Underlying Exam burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

Yo the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2X 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\overline{\mathbb{M}}\) Residence 6 \(\sum \) Other (Specify) မ 1 Tes 2 **X X**No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred XX Natural 5  $\square$  Pending ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b 9c. License number 29d. Date signed (Month, Day, Year) 30. Name and addit person who completed cause of death (Item 23a) (Type, Print) Ivan Zama MD 9200 Basil Court #200 Largo, Maryland 20774 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 4 2010 acks Registrar

DHMH 17 Rev 7/2009

Amended #1 Kent Co		,11/7/10, C.C.	ease T	ype or Pr State of M	<b>int in I</b> Iarylan	d / Depa	artmen	nt of H	lealth	ure A and N	All Copie Mental Hy	s Ar gien	re Legi le	ble.	1.1210
		Registrar  1. Decedent's Name (First, Min	idle last)			Cer	tificat	e ot L	eatn		2. Date of D	Reg. N	40. L U	1 0	41210
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		7934 AIRY HILI	ROAD				4b. City, Town, or Location of Death  CHESTERTOWN						KEN!		
Funeral		5. Social Security Number	6. Sex		ge (In yrs. la	ast birthday)	If Under		If Under Hours	24 Hrs.	8. Date of Bi	rth		9. Birthi	place (State or Foreign
Director		155-28-0635 Usual Residence of Decedent	I.A.	M Z L F	7	4 Yrs.	Wonths	Duyo	Hours	IVIIII.	02/19/	193	6	NEW	JERSEY
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Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inprotant: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fi	11. Marital Status 1 ☐ Never Married 21☐ 1		Armed Forces?							ecify Yes or No Rican, etc.)	•		- Americ , White,	an Indian, etc.
JO3	ed	3 Widowed 4 Divor		If Yes, Give Year or Dates.		1	☐ Yes	2 XNo	Specify:				Specify:	WHI	TE
2 hou	l be	15. Dece (Specify only hi	dent's Educ			16a. Deced	kind of wor	rk done d		t of work	ing	16b.	Kind of Bus	iness In	dustry
21215-0036 within 72 hours after giene. er than "natural", o, the Medical Exami,	Be Completed	Elementary/Seconday (0-1.	2)	College (1-4 or	5+)	life. Do	O NOT use	· .	door			_	nsura	nce	
d 2	Be	17. Father's Name (First, Midd	e, Last)	4		Сощрт	Tance	2 011		er's Nam	e (First, Middle			iice	
land de finder d	P	Albert Middle	ton Pa	rry				ŀ			ornor	,	,		
Maryland 2 should be filed th and Mental Hy 27 is marked oth traumatic event		19a. Informant's Name/Relation				19b. Mailir	g Address	s (Street a	nd Numbe	er or Rura	al Route Numb	er, City	or Town, Sta	ite, Zip (	Code)
nd 2. m 27		Linda Platt Pa	arry /	Wife		7934	Airy	Hill	Roa	d Ch	esterto	wn,	Mary	land	21620
DOF De 1 a It of H or oth		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremati	on 3 ☐ Re	moval from State	, 0	lace of Dispo emetery, cren	natory or o	ther place			Date	20c.	Location - C	City or To	own, State
Baltimore, sernit. Page 1 and Separtment of Hee mportant: If item into Injury or othe more.		4 Donation 5 Othe			CHE						4/2010				RYLAND
Bal permit Depar Impol any In	ļ	21. Signature of Funeral Service		1. 10	- ,	FE	LLOWS	Addres	s of Facilit	BEIN	& NEW	ĮAM,	FUNER.	AL H	IOME, P.A. 21620
		23a. Part 1. Enter the disease	, or complica	ations that cause	d the death	n. Do not ente	r the mode	e of dying	g, such as	cardiac o	or respiratory a	rrest,	IAKILA	ND 2	Approximate
Physician/		shock, or heart failure. Li Immediate Cause (Final	st only one o	ause on each lin	11.	0	no				. ,			8	Interval Between Onset and Death
Medical	Ι.	disease or condition resulting in death)	<b>a</b> . a.	Die to (or as	a consequ	1	MO								
Examiner	<u>.</u>	Sequentially list conditions,	b.												
p ii	i e	if any, leading to immediate	2	Due to (or as	a consequ	ience of):									
executed an and ial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c.	Due to (or as	a consequ	ence of):								+	
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376 ficate g phys	<b>J</b> edi		0.								-				
Box 68760 death certificate be attending physiced for use as the beather.	ar	IF FEMALE: 23b. Was decedent pregnant	230	. If yes, outcome 1 Live Birth			Ectopic	preanance	,				23d. Date	of deliv	ery
Boy death he att	Completed by Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown		4 Pregnant	at time of d	leath 5	Other (sp	pecify)	···				Mont	:h	Day Year
P.O. Bc; that the dea	듄	Part II. Other significant cond	litions contri	buting to death	out not resi	ulting in the u	nderlyina a	cause giv	en in Part	1	22a Did	tobacca	l una contrib	uto to th	ne cause of death?
S, P.(	db	3				g c	,	g.,		••	1 🗆				bably 4 🗆 Unknown
ords	lete										24a. Was				psy findings available
/ital Reco sician: The law is certificate has birector, page 2 s	ᄩ			-	-						auto	<b>Q</b> Sy	pr de	ior to ce ath?	mpletion of cause of
an: The tifficat tor, pa	Be C	25. Was case referred to medic	al					26. Pla	ce of Dea	th (Chec	1 L Yes	2	No 1	Yes	2 No
Vita	₽ B	examiner? 1  Yes 2 No	Hos	pital: 1	ient 2 🗌	ER/Outpatien	t 3 🗆 DC	Otho	F-1		me 5 Res	idence	6 ☐ Other	(Specify	)
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tendi death. tor: A the fu	Certificate:	2 Accident Inve	estigation ald not be				М	1 🗆	Yes 2 🗆	No					
Division of Vital Records, all or Attending Physician: The law requires stafter death.  In Director: After this certificate has been signed in by the funeral director, page 2 should be	Ser		ermined	28e. Place of Inj building, et			et, factory	, office			28f. Location ( City or To			or Rural	Route Number,
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu		29a. Certifier Certify	ing Physicia	an: To the best of	my knowle	edge, death o	occured at	the time	date and	place ar	d due to the o	ause(s)	and manner	as state	rd.
he Ho in 24 h he Fui pleted	Medical	(Check 2 L Medic	al Examiner:	On the basis of e	examination	and/or invest	igation, in r	my opinio	n, death oc	curred a	the time, date	and place	ce, and due t	o the car	use(s) and manner stated
To th		29b. Signature and title of cert		~			29c	. License	number	<u> </u>			ate signed (		*
20		<b>)</b> / Y				Mi	9. 1	700	<b>17</b>	86			121	3	10
+		30. Name and address of pers	_	_	leath (Item	23a) (Type, P		101	נה ו	^	1. 1	1	~	~ <i>n</i>	21. 2-
رد Sta	to	31. Date filed (Month, Day, Yea	erqu	32. Aegistr	ar's Signet	7/200	R Re	d Bli	19 B	<u>. C</u>	nester	tou	un 11	117	21430
Registra		DEC U		Den	A K	1. pa	and I		J						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 12/07/2010 Physician/ 0029 LESTER PURNELL Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Montgamery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 X M 2 □ F Months Days Hours 06/12/1942 Director 219-36-7078 68 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🄀 No Rockville MD Montgamery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 13307 Keating Street 20853 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1X Yes 2 No 1962-Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Raltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black "natural" Completed 3 Widowed 4 Divorced 1967 the Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) United States of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clara Foreman Rubin Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 13307 Keating Street, Rockville, MD 20853 Barbara L. Purnell/wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donaţion 5 ☐ Other (Specify) crematory or other place) 12/11/10 Silver Spring, MD οE Heaven Cem. Funeral Service License 22. Name and Address of Facility Snowden Funeral Home Signatur 246 N. Washington St, Rockville, MD 20850 ations that caused the de n. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1. Enter the disease or complic shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Bilateral frontal lobe strokes Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner months Stage 4 lung cancer Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? ō Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes ∠ ⊏ 9 ☐ Unknown the detached þ Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Seizures, hypertension, cardiomyopathy 1 Kayes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 perform Yes 2 X after death.

Director: After this certificate Yes 2 × No 26. Place of Death (Check only one) funeral director. 25. Was case referred to medical Be examiner? Hospital 1 ☐ Yes 2 No Other: <u>ا</u> 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined 24 hours a Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 일 10 Barbara duparuch RSM D 0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

Barbara Supanich
31. Date filed (Month, Day, Year)

0.9 2010

DEC

32. Registrar's Signature

1500 Forest Glen Road, #727, Silver Spring, MD 20910

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar			ate of M	arylan		artmer <i>tificate</i>			and M	lental Hy	giene Reg. N	ZUIL		11220
	Physicia Medic		1. Decedent's Name (I	Denis	2		ld <b>e-</b> R	ando1p	h				2. Date of De Month Dec. 6	-	on Year		3. Time of Death 3:46 p M
Service .	Examin		4a. Facility Name (if no Casey Ho	us <b>e</b> /Mo	ntgom	ery Ho			4b. City, Town, or Location of Death  Rockville						c. County of De		
	Funeral Director		5. Social Security Num 577-80-38	16	3. Sex 1 ☐ M 2		51	st birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours		8. Date of Bir 09/27/		9. E	Sirthpla Country C	ce (State or Foreign ')
	iryland I-f show Ied at	Director		Ob. County		10c. City, Town or Location Washington										100	d. Inside City Limits
	h the Ma ka or 28a be notif		10e. Street and Number						10f. Zip					10g. C	itizen of What	Country	
	death wit items 23 ier must	Funeral	4649 Hil	Iside	12. Wa	S. E		13.		019	spanic Orig	gin? (Spe	cify Yes or No-		14. Race - An	nericar	
9800	2 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	ted by	1 Never Married 3 Widowed 4	Divorced	ed 1 [ If Ye	☐ Yes 2 🛣 ∕es, Give ar or Dates.	No	.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ▼ No Specify:							Black, White, etc. Specify: Black		
1215-	thin 72 ho sne. than "nat	Completed		15. Decedent fy only highes day (0-12)	grade com		+)	life. D	dent's Usua kind of woi O NOT use icate	rk done di retired)	uring most		ng		Sb. Kind of Business Industry Giant Foods		
Maryland 21215-0036	and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at	To Be (	17. Father's Name (Fire Melvin Pr		st)				ICAC	z s s e i	18. Mothe	er's Name	(First, Middle,	Maider	Surname)	000	15
	d 2 should alth and M 1 27 is ma er trauma:		19a. Informant's Name Delonta			(Sor	n)	19b. Mailir 9220	-						r Town, State, I	•	<i>'</i>
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 2		20a. Method of Dispos 1 ☐ Burial 2 🛣 4 ☐ Donation 5	Cremation	3 ☐ Remov	al from State	20b. P	lace of Dispo emetery, crer Sapeak	sition /Nan	ne of			lete	20c. l	ocation - City	or Tow	n, State
Balt Balt			21. Signature of Funer			L CCDS	18	22 W	Name an H . 447 1	d Address Baco 4th	s of Facility n Fur	eral	Home,	Ind Wasi	c. hington	. D	C 20010
	Physician/ Medical Examiner  e private transit	dical Examiner	shock, or heart failure. List only one cause on each line.											Approximate nterval Between Inset and Death			
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and gompleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	₩	IF FEMALE: 23b. Was decedent prointhe past 12 mo 1 ☐ Yes 2 🛂 t 9 ☐ Unknown		1 [ 4 [	ves, outcome Live Birth Pregnant a Unknown	2 🗌 Feta	Ideath 3	Ectopic p		/				23d. Date of o	,	/ ay Year
s, P.O.	ires that the signed by detail	ξ Ω	Part II. Other significa	ant condition			ut not res	ulting in the u	nderlying o	cause give	en in Part I						cause of death?
Division of Vital Records,	The law requ ate has been bage 2 shoul	Completed		-									24a. Was auto perfo	psy rmed?	prior to death	comp	y findings available bletion of cause of
/ital	sician: The law certificate has b lirector, page 2 s		25. Was case referred examiner?		Hospita	l:		SD/0-4		Othe	ce of Deat		only one)				
on of \	ending Phy sath. or: After this he funeral d	Certificate: T	27. Manner of Death  1   Natural  2   Accident	5 Pending	ition	a. Date of inju (Month, Day	ry	ER/Outpatier 28b. Time of injury		8c. Injury work?	_4 ∟ Nu at	2	ne 5 L. Resid			ecify)	Hospice
Divisi	ital or Atturs after de ral Directo		4  Homicide	6 Could n determir	ed 28e	. Place of Injubulding, etc	. (Specify,						City or Tov	vn, State	,		oute Number,
	the Hosp nin 24 hou the Fune ppleted fil	Medical	(Check 2 L only one) 3 L	Medical Ex   Certifying I	aminer: On	the basis of e	kamination	and/or invest	tigation, in r	ny opinior	n, death oc	curred at	the time, date a	and plac	and manner as s e, and due to th (s) and manner	e cause	e(s) and manner stated.
	I I I I I I I I I I I I I I I I I I I		29b. Signature and title	Enle		~~				License D 3	number 37142				ate signed (Mor ecember		
			30. Name and address G. Cole	of person w	no complete	ed cause of d	eath (Item Picc	23a) (Type, F ard Dr	rint)	Roc	kvil:	le, 1	Md.				
	Stat Registra		31. Date filed (Month, I	Day, Year) 2	010	32 Registra	r's Signat	re fo	N. S.								

State of Maryland / Department of Health and Mental Hygiene [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:00 A.M Benjamin Peery November 30. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1204 Dale Drive Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth (Month, Day, Funeral 6. Sex 9. Birthplace (State or Foreign Days 1 ★ M 2 □ F Director 472-16-4153 88 March 4,1922 Missouri Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1204 Dale Drive 20910 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 ★ Yes 2 No If Yes, Give WW II Year or Dates 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Benjamin Peery Caroline Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Darnelle Macklin Peery/Wife 1204 Dale Drive, Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 30 cemetery, crematory or other place). Geo. Wash. University Medical Center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Congestive Heart Failure disease or condition Weeks Medical resulting in death) Due to (or as a consequence of Examiner 15 Years Atherosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) e burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atherosclerotic Cerebrovascular Disease 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 1 Yes 2 No Yes 2X No Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🙀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work?
1 Yes 2 No Investigation 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Wenstork us D009748 December 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10313 Georgia Avenue Suite 105 Alan Weinstock,  $M_{\bullet}D$ Silver Spring, MD 20902 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

68760

Box

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year SEpt • 11, Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Washington, 1 **X** M 2 □ F Director 577-22-8754 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No 28a-f Silver Spring Maryland Montgomery ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 14509 Elmhan Court 20906 USA 23a Funeral items death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 No f Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced WWII Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Printing Lithographer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernesto Postorino Maria De Leo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Fyock/Daughter 2900 Excelsior Springs Ct., Fllicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. 13. cemetery, crematory or other place)
Gate of Heaven
Cemetery 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Silver Spring, MD Signature of Fureral Service License 2francisdgs of Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Preysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **∲Examiner** pivaltan if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury -transit that the death certificate be executed that initiated events Due to (or as a consequence of) ing physician are as the burial-t resulting in death) Last Physician/Medical Box 68760 IF FEMALE ettendin 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s or Attending Physician: The law has autopsy perform nis certificate h I director, page 1 Yes 2 No of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2. No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 욘 this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Division 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3064-1 2+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back River neck Road Sabapalli 10 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Virginia Manning December 7:38 P M Rintou1 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Solomons Nursing Center Solomons Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Days Hours 02<sup>M</sup>2<sup>th</sup> / 1 917 **Director** 212-03-8593 93 Yrs. Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 X No MD Calvert Dowe11 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20629 USA 716 Ruxton Road 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Specify: Completed 3 ☑ Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry L. Manning Estalene Golden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jenny Lee Dodd/Daughter 716 Ruxton Road Dowell, MD 20629 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/23/2010 Warfordsburg, PA Warfordsburg Presby. Signature of Funeral Service Licen 22. Name and Address of Facility 141 West Main Street OO (co) Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ **Medical** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Pregnant at time of death signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 25 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2200 မှု 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical In the less of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of December 21, 2010

Registrar
DHMH 17 Rev 7/2009

101

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

MD 110 Hospital Drive, Suite 300, Prince Frederick, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gwyneth Blattau,

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Irene Farinaccio Ruby 2010 2323 P M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Vicamico isbur If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Davs Min (Month Day Year) 87 Director 216-14-4097 Maryland Usual Residence of Decedent show 10b. County filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 601 Parker Road 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give า "natural", or item ledical Examiner ก 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 X Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) seamstress clothing manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I tem 27 is marked of ဥ Page 1 and 2 should be Nicholas Farinaccio Angeline Pitroniero 19a. Informant's Name/Relationship (Type, Print)
Phyllis Twilley/daughter 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 601 Parker Rd•, Salisbury, MD 21804 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other it Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Springhlilly Mellory Gardens 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🕱 Other (SpecifEntombment 12/9/2010 Hebron, MD Signature of Funeral Service Licensee ਜੋਠੀ ਪਿੰਡ ਵਿਧਾਰ ਦੀ Home Professional Ass 501 Snow Hill Rd., Salisbury, MD 21804 Associaiton avid Compson CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2: No Day 5 Other (specify) Pregnant at time of death signed by the Unknown 9 Unknown Part II. Othe<mark>r significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uaknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 Yes 2 No 1 Yes 2 🗓 N To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 21/10 1 🖺 Inpatient 2 🗌 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide within 24 hours after death

To the Funeral Director: A
completed filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide City or Town, State) Medical 29a, Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 3 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phta 29 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER<sup>ay</sup> 7 2010 5:39 P M ROUSE ANITA JOHNNIE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S BOWIE HEALTH CENTER BOWIE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛚 F Days Hours Min. JUNE 5, 1943 SOUTH CAROLINA 228-62-3023 Director 67 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked of other than "natural", or items be notified at she injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No PRINCE GEORGE'S UPPER MARLBORO MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral USA 20774 11601 MIDDLEHAM DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married BLACK 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify Completed 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) DEPUTY DIRECTOR GOVERNMENT 5 YRS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ BERNICE MCDOWELL JOHN ROUSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 11601 MIDDLEHAM DRIVE UPPER MARLBORO, MARYLAND 20774 BENNIE THAYER BLOUNT/NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal 12/15/2010 CHEASPEAKE, VIRGINIA 4 Donation 5 Other (Specify) ROOSEVELT MEMORIAL Signature of Funeral S J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition ARTERIOSCLEROTIC HYPERTENSIVE HEART DISEASE Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALÉ: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 XNo Year Month Day Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wunknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Bowie Health Cnt. Other: 4 Nursing Home 5 Residence Hospital: မှ 2 🗌 No 6**X** 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H55927 2010 DECEMBER 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVANDOR SYLVESTER MD 255 ROCKVILLE PIKE SUITE #125 ROCKVILLE, MARYLAND 20850 Date filed (Month, Day, 32. Registrar's Signature State **UEC 1 4 2010** Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 2 8

		1- For State Registrar	•	ate of Death	7		Re	U 1. g. No.				
Physicia edical Exami	an/	1. Decedent's Name (First, Middle, Last)  Dutchess Marie Riggins					Date of Death     Month     December	Day Year	3. Time of Death 1835 hrs			
		4a. Facility Name (if not institution, give street and number) 301 E. Main Street Apt 2			own, or Loc ninster	ation of Death		4c. County of Carroll	Death			
Funeral Director		220-92-6992 1□M 2⊠F	yrs. last birth	rday) If Under Months Yrs.		f Under 24Hrs Hours Min.	-	8, 1979	9. Birthplace (State or Foreign Country) Maryland			
w any			City, Town o	or Location	T <sub>M</sub> 7	estmins	rtor		10d. Inside City Limits  1 Yes 2 No			
r death with the Maryland nr items 23a or 28a-f show any must be notified at once.	Director	Maryland Carroll  10e. Street and Number  301 East Main Street Apt 2		10f. Zip		21157		g. Citizen of What USA	t Country?			
th with the ems 23a o	75	11. Marital Status  1 Never Maried 2 Married Armed Forces?	in U.S.	13. Was Deceder If Yes, specify		ic Origin? ( Sp			American Indian, Black,			
s after dea	by Funer	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 Yes 2	-		vodi dono	Specify:	Black			
11215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner.	Completed	15. Decedent's Education (Specify only highest grade complete  Elementary/Secondary (0-12)  College (1-4 or 5+)  2		uring most of work				Non				
215-0036 be filed within 7 and Hygiene. rked nther than ent, the Medica	Be Com	17. Father's Name (First, Middle, Last) Ulysses Riggins			18.		(First, Middle, M Howard	aiden Sumame)	· <del>· · ·</del>			
and 2 should be lealth and Ment tem 27 is marl traumatic eve	ToE	19a. Informant's Name/Relationship (Type, Print) Mary E. Riggins, mother		Mailing Address O Charle								
Baltimore, MD 21215-0036 permit. Pages I and Stould be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked nither than "natural", ar items 23a or 28a-f sho injury or other traumante event, the Medical Examiner must be notified at once	İ	1 Burial 2 Cremation 3 Removal from State	Soutela	Disposition (Namery or other place)			Date 16/2010	20c. Location - C	ity or Town, State			
Baltin permit. P Departme Importar	,	4 Donation 5 Other Specify: 2 Signature of Funeral Service Licensee	>	22. Name and	Address of I	Facility Mye	ers-Durb	oraw Fun ster, MD	eral Home 21157			
Physician /Medical	a comment	23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.  Hyperten		enter the mode of	f dying, suc	h as cardiac o	respiratory arre					
<i>E</i> xaminer		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,  a. Thy Police III Due to (or as a consequentially list conditions,										
	Examiner	if any leading to immediate Due to (or as a consequence of):										
kecuted	ai Exa	d.										
760, icate be executed physician and the burial - transit		IF FEMALE: 23c. If yes, outcome of		per ME				23d. Date of de				
Box 687 e death certific the attending g ed for use as th	Physician/	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  1  Unknown	of death 5	Fetal death Other (Speci		Ectopic pregna		Month	Day Year			
ires that the signed by t	2	Part II. Other significant conditions contributing to death but r Chronic Abstructive P			-	n in Part I.			te to the cause of death?  Probably 4 ✔ Unknown			
cords law requi	Completed						24a. Was ar autops perform 1 Yes 2	y prid ned? dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 No			
tal Recient: The certificate	Be	25. Was case referred to medical examiner? Hospital: 4 Inspetion 1.3			Oth	Death (Check of						
on of Vi nding Physi th. After this c funeral dir	욘	1 ✓ Yes 2 No Prospiral 1 Inpatient 2  27. Manner of Death 1 ✓ Natural 5 Pending		ime of Injury 2	8c. Injury at	Work?		esidence 6 🗹				
Division Bospital or Attence 24 hours after death Puneral Directors stely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	At home, far	m, street, factory,	office build	ng, etc.	28f. Location (St or Town, Sta		or Rural Route Number, City			
Di Tn the Hospital Within 24 hours a To the Funeral I completely filled	Medicai C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	_									
WIL	Me	29b. Signature and title of certifier	(,))	29c.	O.C.M.E			29d. Date signed  December 1	(Month, Day, Year) 5, 2010			
0		30. Name and address of person who completed cause of death ( Russell Alexander MD. Assistant Medical Ex		111 Penn S	treet, Ba	Itimore, MI						
St		31. Date filed (Month, Day, Year)  32. Registrar's Sig	gnature	/								

ORIGINAL

UUNE

DHMH 17 Rev 1/2001 OCME 2006

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.													
	<b>1 - State</b> Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 0 1 2 2 3													
Physicia	n/	Decedent's Name		•					2 Date of De		Year	3. Time of Death		
Medic	al	4a Escility Name (if	Angela	Roque ive street and number)			41. O't. Tour	Lassian of Docti	1/etam	Verember 7 2010 11:520				
Examine	er	, ,	, 0	y Hospital			Lanham	Location of Death	1	4c. County of Death Prince George				
Funeral Director		5. Social Security Nu. 579-35-17	1	1 M 2 17 E	ge (In yrs. Ia 7 <b>4</b>	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	8. Date of Birth 9. Birthplace (State or Fore Country)  107-05-1936 E1 Salvador				
		Usual Residence of 10a. State		- '					10. 00		1111			
larylan 3a-f sh iffied a	Director	DC	Nor	ne		y, Town or Lo <b>ashing</b>						10d. Inside City Limits 1    Yes 2 □ No		
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ath wit	Funeral	301 Delai	field Pl	ace N.W.		S [13	20011 Was Decedent of Hi	spanic Origin? (Sr		E1 Salvador				
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ours a	eted	3 🕅 Widowed 4	4 Divorced	If Yes, Give Year or Dates.			1 X Yes 2 □ No		vadoran	1 401 14		cify: Hispanic		
in 72 h e. nan "n . Medi	Completed	(Spec	cify only highest	grade completed)  College (1-4 or	5+)	(Give	kind of work done on NOT use retired)	during most of wor	king		Kind of Busines			
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l be file fental H rked o	To E	Teodoro F		t)				18. Mother's Nar Rosa Em	ne <i>(First, Middle,</i> ilia Val					
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na					-					own, State, Zip Code)		
and 2 Healt tem 2 other		Nelly Ur 20a. Method of Disp		(Daughter)	20b. F	lace of Dispo	L St. Fai	1	Date		ocation - City o			
Page 1 nent of ant: If i		1 🔀 Burial 2 🛭 4 🗋 Donation	☐ Cremation 3 5 ☐ Other (Spe	☐ Removal from State cify)	C	emetery, crei	matory`or other plac metery		13-2010		Salvado			
permit. Departr Importa any inji		21. Signature of Fun	neral Service Line	ensee	-10	2:	2. Name and Addres							
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hysician/		shock, or hear Immediate Cause (F disease or condition	Final	one cause on each lin		mai	1 cei	1 com	ero	FL	UNG	Interval Between Onset and Death		
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eath certificate be eatending physicied for use as the bur	Physician/Medical	23b. Was decedent p in the past 12 m 1 Yes 2	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant	2 Feta	Ideath 3	Ectopic pregnanc Other (specify)	у		23d. Date of delivery  Month Day				
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cate ha				,						rmed?	death?			
sician: certifii rector,	Be	25. Was case referre examiner?  1  Yes 2		Hospital:			Othe	ace of Death (Chec		-				
ng Phys fter this ineral di	ite: To	27. Manner of Death		28a. Date of inju	ırv	28b. Time of injury	nt 3 🗆 DOA	4 ∐ Nursing H rat	ome 5 Residence 128d. Describe h			cify)		
death. ctor: A y the fu	Certificate:	2 Accident 3 Suicide	Investigati 6  Could not	ion be 200 Blace of Ini		me farm str	M 1 🗆	Yes 2 No	28f Location /9	Street an	nd Number or R	tural Route Number,		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										vn, State	2)			
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2	Medical Exa	nysician: To the best of miner: On the basis of e urse Practioner: To the	examination	n and/or inves	tigation, in my opinio	n, death occurred	at the time, date a	and place	e, and due to the	e cause(s) and manner stated.		
3 vith		29b. Signature and ti	itle of certifier	Mode	((->	5~1	29c. License	number 2596	181	29d. Da	ate signed (Mon	th, Day, Year)		
			ess of person who	completed cause of a		23a) (Type, F	Print) 8/1/8	Good Li	ill Rd.	Lanl	ham MI	7. 20106		
State Registra	_	31. Date filed (Month	n, Day, Year) 09 201	22. Registr	ar's Signat			V	,		, 0			
	_			-	_									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 Physician/ 8:33 p<sub>M</sub> Month Rigoberto Ramos December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 Honduras **Funeral** 216-98-0771 Months Days Hours Min (Month, Day, Young 28, 1 1 M 2 | F Director Yrs. 1945 65 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at Director 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Potomac 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9301 Inglewood Court 20854 LISA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married Married ò Yes 2 12 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 😿 Yes 2 🗆 No Specify: Honduran White 3 Divorced 4 Divorced Specify: Completed I Hygiene. d other than "natura" event, the Medical F 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Gardener Landscaping æ injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Antonio Ramos Carmen Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nimnuan Matang/Wife 9301 Inglewood Court, Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery De 2018 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. En . r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerota Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner iabete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? After this certificate 1 ☐ Yes 2 ☐ No Vital To the Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 No မြ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Division of 27. Manney of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

3

BEATO

YAMOS

Matthew M. Leonard, MD 8600 Old Georgetown Road, Bethesda, MD 20814

Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
AND Health
Fr. M.E. 12/20/10 ONH Certificate of Death Alyssa Marie Salazar 1- For State AMEND#4BC /20/10 CMH Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day December 3, 2010 0505 hrs **Medical Examiner** Alyssa Marie Salazar 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frostburg Frostburg Allegany 82 East Main Street If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Maryland
Country 12/03/1990 Min 20 Months Davs Hours Director 1 M 2 XF 214-31-5489 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Annapolis MD Anne Arundel 1 Yes 2 X No narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21409 USA 1630 Trawler Lane Funeral 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. White etc Armed Forces? 1 X Never Married 2 Married Costa Rican 2 X No Yes Hispanic If Yes, Give Year 1 X Yes 2 No specify: Specify: 3 Widowed 4 Divorced ۾ or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) College Student Baltimore, MD 21215-0036 marked other 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cynthia Trevion Trevino Be Alonso Salazar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is Cynthia M. Salazar / Mother 1630 Trawler Lane Annapolis, MD 21409 20a. Method of Disposition December 2010 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Lakemont Menorial Gardens 1 X Burial 2 Cremation 3 Removal from State Davidsonville, MD Important: injury or oth 4 Donation 5 Other Specify 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral-Service Licenses 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Madies Death a. Smoke Inhalation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown been signed by the bould be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has death? performed? 1 Yes Yes 2 ✔ No 26.Place of Death (Check only one) 25. Was case referred to medical director, Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other Scene this 1 🗸 Yes မှ 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Victim of housefire Dec 3, 2010 1 Natural 0417 hrs 1 Yes 2 ✓ No Pending within 24 hours after death To the Funeral Director: 2 🗸 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 82 East Main Street, Frostburg, MD determined (Specify) Multi-Family Apt. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 4, 2010 O.C.M.E. where

OGME

n 2010

Laron Locke MD

31. Date filed (Month, Day, Year)

ess of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

arker

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12/109/2010 ear 2:30 a M Larry Eugene Shoemaker Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert 3620 King Drive Dunkirk If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Min. Months Hours 1 🖳 M 2 🗆 F 218-66-3913 55 0272871955 Director MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Calvert Dunkirk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20754 U.S.A. 3620 King Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) CES Security Security Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Pauline Lorriane Hutchison William Vincent Shoemaker, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Shoemaker/Wife 3620 King Drive, Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2x Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/10/2010 Lee Crematory Clinton, MD Signature of Fulleral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, 8125 Southern Md Blvd., Owings, MD 20736 Isa M. Mounts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of: death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Successful time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 1 Yes 2 🗌 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: s after dearn. al Director. After this c 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completed filled in by the ☐ Suicide. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner: To the best of my in owledge, death occurred at the time, date and place, and due to the causelet and manner as stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D0027189 2010 KN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZAHIR YOUSAF 2417 Solomons Island Rd. Hautingtown, Md M.D

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

DEC 13 2010

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 7. Rochelle Gay1e Salvas 2010 1:45 A. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town or Location of Death 4c. County of Death 2700 Apple Way Calvert Dunkirk 5. Social Security Number 7. Age (In vrs. last birthday 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Days Hours 0970471935 Director 407-46-2178 Kentucky Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits "natural", or items 23a or 28a-f s edical Examiner must be notified MD Calvert Dunkirk 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2700 Apple Way 20754 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: Completed white Year or Dates marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Willis Sue Frances Ha11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew E. Salvas, husband 2700 Apple Way, Dunkirk, MD 20754 or other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Gardens 12/10/2010 Dunkirk, MD Signature of Funeral Service Lie 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearn allure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ cate has been signed by the atte page 2 should be detached for Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) 1  $\square$  Yes ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Xcertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Signature Registrar

Please Type or Print in Black Indelible Ink. Frayin All Copies Are Legible. Amend 25 per med cert G911k. Frayin All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 12/9/2010 6:01 A Sally Palmer Shipley /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3 Westminster Dr. Berlin Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/20/1969 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗙 F MD Director 215-88-3933 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or 18 marked other than "natural", or items 23 a or 28 a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐Yes X☐No Directo MD Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3 Westminster Dr. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify:white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Patient Coordinator Atlantic Dental injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rollie Palmer Roberta Willis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Westminster Dr. Berlin, MD 21811 Mark Shipley (husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pittsville Cemetery | 12/14/2010 | Pittsville MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Fuperal Service Licensee 108 William St. Berlin, MD 21811 SOY Approximate Interval Between Onset and Death 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Cause (Final multi lorma 17 lioblastoma **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) ed by the a detached f 1 Yes 2 No 9 Unknown signed I d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con tute to the cause of death? ģ 1 ☐ Yes 2 1 0 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 **N**o To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 🛣 No P 2 ER/Outpatient 3 DOA 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the f 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature ar title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address person who completed cause of death (Item 23a) (Type, Print) moll St, Salisbury MD 21801 D1 10 th, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:15 p.M Leslie Ernest Stephenson, Sr. Dec. 3. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 15106 Eastview Drive Baltimore Upperco 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 🗆 F Months Days Hours Min. 67 214-40-7736 Director 6/30/1943 MD Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Baltimore Upperco 1 Yes 2 No 10e Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 15106 Eastview Drive 21155 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: white Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Repair 12 <u> Auto/Truck Technician</u> other traumatic event, Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other transmerting ones 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edmond Leslie Stephenson Grace Sparks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline E. Stephenson, wife | 15106 Eastview Drive, Upperco, Md. 21155 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Carroll Cremation 12/6/2010 Hampstead, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00741 han 934 Main St., Hampstead, Md. 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Amy otrophic
Due to (or as a consequence of): SUPJUSIS disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page perform death? Yes 2 No 2 100 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 🗆 Yes 2 No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Certificate: Hospital or Attending work?
1 Yes 2 No To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

8

29a. Certifier (Check

Todd

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1075?

Falls

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

State Registrar Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

059

29d. Date signed (Month, Day, Year)

2016

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 5 2010 Physician/ BARBARA JEAN STATEN 1905 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville montgomery Grove Adventist Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 80 1 M 2 X F 10/27/1930 OH Country) Director 270-26-9618 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Montgomery Montgomery Village 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 9440 Fern Hollow Way 20886 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Specify: Black Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesperson Bloomingdales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ should be Robert S. Fields Helen M. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Wanda Brown/daughter 9440 Fern Hollow Way, Montgomery Village, MD 20886 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from St 4 Donation 5 Other (Specify) Homestead Cem. Youngstown OH 12/15/10 . Signatur Funeral Service Licens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only ope tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Si Medical Due to (or as a consequence of) Examiner F 004 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ne attending physician and ad for use as the burial-trast Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) Day Month Year Pregnant at time of death signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Pneumothorax 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of 24 hours after death. Funeral Director, After this certificate has autopsy performed? Yes 2 death? 2 🗌 No Yes 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be 1 Yes 2 🗌 No Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0062435 ecember 6,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville ELSayyad 10110 molec MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar 09

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12/5/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death tewart Physician/ Month opert 24 PM 010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore Baltimore City If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 X M 2 🗆 F Hours (Month, Day, Year) 05/16/1968 216-02-3446 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at vermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Xyes 2 □ No Anne Arundel MD Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7733 Telegraph Road, Trailer 24 21144 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian Black. White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hair Stylist Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert F. Stewart, Sr. Anita Barron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. Stewart, Sr. -father 11619 Summer Oak Drive, Germantown, MD 20874 20a. Method of Disposition 20b Place of Disposition (Name of cemeter); crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from 4 ☐ Donetion 5 ☐ Other (Specify) Brooke Grove Cem. 12/03/10 Laytonsville, MD 21. Signature of Funeral Service 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or comshock, or heart failure. List only of olications that caused the death ne cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ epticemia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to for as a sonsequence To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No. 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number mansi 25676 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 22

Registrar DHMH 17 Rev 7/2009

State

Samantha 31. Date filed (Month, Day, Year) S. Greene St

32 Registrar's Signature

2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 10:20 р. м 2, Η. Salvail Dec. 2010 Catharine 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Min. 1 □ M 2 🕱 F Yrs. 224-07-9859 90 Jan. 21, 1920 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1x Yes 2 □ No D.C. None Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4800 Sedgwick Street, N.W. 20016 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospitals 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Hassett Lena Lavell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas M. Corcoran/Son 7652 Westlake Terrace. Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. Dec. 9, 2010 Silver Spring, MD Signature of heral Servi 22. Name and Address of Facility DeVol Funeral Home M01315 2222 Wisconsin Ave. N.W. Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertensive Heart Disease disease or condition resulting in death) Due to (or as a consequence of): Cancer of Rectum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Dementia Due to (or as a consequence of): ant s? 23d Date of delivery Month Day Year conditio n Part I.

Physician /Medical Examiner

physician

**Physician** 

/Medical

**Examiner** 

10a State

**Funeral** 

Director

28a-f show

or items 23a or

'natural"

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Hem 27 is marked other the any injury or other traumatic event, Inc. 0nce.

Director

Funeral

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Completed

Be

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event, the Medical Examiner must be notified at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Physician/Medical Examiner burial-transit the as asn for cate has been signed by page 2 should be detact Be Completed by funeral director, Certification: To

a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Property: After this certificate has been signed by the attending physician and the contraction.

Division of Vital Records, P.O. Box 68760,

that initiated events resulting in death) Last
IF FEMALE: 23b. Was decedent pregn in the past 12 month: 1 □Yes 2 ☑ No 9 □ Unknown
Part II. Other significant of

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)
the underlying cause given i

	23e. Did tobacco use contribute to the car	use of death?
	1 ☐ Yes 2 ☐ No 3 ☐ Probably	4☑ Unknown
	24a. Was an autopsy performed? 1 □ Yes 2 ☒ No 1 □ Yes 2 □	
ath (	h (Check only one)	
Home	ome 5 Residence 6 Other (Specify)	
28	28d. Describe how injury occurred	

				1 ☐ Yes 2 🖾 No	1 □Yes 2 □No	
25. Was case referred to medical examiner?			26. Place of Death	(Check only one)		
1 Yes 2 No		Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ D	me 5 ☐ Residence 6 ☐ Other (Specify)			
2 Accident	Pending investigation		8d. Describe how injury	occurred		
3 ☐ Suicide 6 4 ☐ Homicide	6 □ Could not be determined	28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	y, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1⊠	Certifying Ph	ysician: To the best of my knowledge, death occurred	at the time, date and place, a	nd due to the cause(s) a	and manner as stated.	

	(Check only one)	2☐ Medical
į	29b. Signature and	title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

40 rules

D0047330

29d. Date signed (Month, Day, Year) December 3, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas V. Joseph M.D. 50 West Edmonston Drive #207, Rockville, Md. 20852

State Registrar

completely filled in by

To the I within 2 Medical

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Month Thelma Veronica Simkins 4:10 рм Dec. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 230 Whitmoor Terrace Silver Spring Montgomery 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) D . C . 1 ☐ M 2**X**☐ F Months Days Hours Min. (Month, Day, Yo Director .ĭ919 578-07-0679 91 Sept Usual Residence of Decedent show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 230 Whitmoor Terrace 20901 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 H No Specify: If Yes Give 3 X Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ည William B. Maske Sara V. Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Susan Jane Rose/Daughter 11128 Mountainview Ln., permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tu Ijamsville,MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
ort Lincoln
Cemetery 13, 1 Burial 2 Cremation 3 Removal from State Dec. 1 2010 4 Donation 5 Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver Inc. Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Renal Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Urinary Outflow Obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami that the death certificate be executed the burial-tran Due to (or as a consequence of) Physician/Medical attending pl IF FÉMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Pregnant at time of death 5 Other (specify) signed by the at Id be detached for 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 Yes 2 No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Augustin 24 hours after death.

To the Funeral Director: After the Funeral Director of the further or the f 1 X Natural 5 Pending work? Accident
Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signa

Shashank Patel,

31. Date filed (Month, Day, Year)

D58962

18121 Georgia Avenue, #102, Olney, MD 20832

Dec. 6, 2010

10	-09438	

Theresa Dianne Thomas

Please Type or Print in Black Indelible Ink. Er	sure All Copies Are Legible.
State of Maryland / Department of Health	h and Mental Hygiene

		1- For State Registrar		(	Certific	ate of	Death		,	Re	eg. No.		
Physici		<ol> <li>Decedent's Name (First, Midd</li> </ol>	le,Last)						2	2. Date of Deat	h		3. Time of Death
Medical Exam	iner	THERESA DIANNE	THOMAS						ļ	Month December	Day Yea 8, 2010	ır	1625 hrs
		4a. Facility Name (if not institution	on, give street and n	umber)		4	b. City, Town, o		of Death		4c. County of		
		Calvert Memorial Hos		15			Prince Free		200		Prince G		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In y		hday)	If Under 1 Ye		er 24Hrs. s Min.	8. Date of Bir	th(MM/DD/YYYY	Foreign	Wachington
Director		579-62-4769	1 M 2X F	62	2	Yrs.				2/26/1	1948	Cou	ntry) DC
any		Usual Residence of Decedent  10a. State											10d. Inside City Limits
<b>*</b>				100.			<i>,</i>					İ	1 X Yes 2 No
yland yland	ģ	Maryland   Calve	rt		Lusby	7	10f. Zip Code				0.6		
e Mar	ire						IVI. ZIP Code			[10	g. Citizen of Wh	iat Count	ry?
5-0036 ed within 72 hours after death with the Maryland lygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once	Funeral Director	8205 Racoon La 11, Marital Status				10.14	20657		1.0/0		USA		
st be	ner	1 Never Married 2 M		cedent Ever	in U.S.		Decedent of Hi s, specify Cuba				14. Race White		an Indian, Black,
er de		3 X Widowed 4 Div	1 Yes	2 <u>X</u> N	lo	<b>1</b> □ .	Yes 2 X No	a specific			Specific	D 1	•
ural'	þ	15. Decedent's Education (Spe	or Dates:		d) 16a		s Usual Occupa			rk done	Specify: 16b. Kind of Bu	B1a	
2 hou "nat	ted	Elementary/Secondary (0-12)		1-4 or 5+)			st of working life				TOD. TAILE OF BE	31110331111	dustry
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", c event, the Medical Examiner	ompleted by	12		,	п.	man	Dogoumo				0		
5-00 led wit Hygien other	5	17. Father's Name (First, Middle,	Last)		] nu	man	Resourc		's Name (F	irst, Middle, M	Governi laiden Surname)		
	Be (	Edward T. Smith	n Sr.					T.011	ise (	ook			
imore, MD 2121( Pages I and 2 should be fil ment of Health and Mental H tant: Uiten 27 is marked or other traumatic event, i	٥	19a. Informant's Name/Relations			198	. Mailing .	Address (Stre	et and Num	nber or Ru	ral Route Num	ber, City or Towr	n, State, .	Zip Code)
ore, MD 2 es 1 and 2 shou of Health and In Item 27 is in		Theresa Gordon	Harley/	Daught	er 8	205	Racoon	Lane	Lusby	. Marv	1and 20	657	
l and l' Heal	m	20a. Method of Disposition		2	0b. Place o	of Disposit	ion (Name of ce	metery,		Date	20c. Location -		own, State
nt: If		1 Burial 2 Cremation					emorial		19/1	E /2010	C	1	M1
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other St. 21. Sonature of Funeral Service		_	LINCO	22. Na	me and Addres	s of Facility	/Popo	.5/2010	1 Homes	ana,	Maryland
ii ii De Pe		Frith A.	MI MI	01085	_	553	8 Marlb	oro P	ike F	Tunela	illa M	, f	and 20747
Physician		23 Parl. Enter the dise se, or	com sications that c			t enter the	mode of dying	, such as ca	ardiac or re	espiratory arre	st, shock, or hea	rt J	Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease		ensive	Care	diova	scular	Disea	ase				Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a			21010	Journal	Disco	450				
	.	Sequentially list conditions,	b										
	miner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequent	ce of):								
	티	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence	ce of):							-	
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760, icate be ex physician the burial	Me	IF FEMALE:		outcome of p	regnancy						23d. Date of o	delivery	
		23b. Was decedent pregnant in th past 12 months?	I LIVE D		2	Feta	I death 3	Ectopic	pregnanc	у	Month	Da	y Year
Box 68 death certif he attending d for use as	Sic	1 Yes 2 V No 9 Unk	nown 9 Unkno	ant at time o	rdeath 5	Othe	er (Specify)						
O. B.	Physician	Part II. Other significant conditi			ot resulting	in the un	derlying cause (	niven in Pa	rt I	23e Did tok	acco use contrib	vite to th	e cause of death?
P.O es that to igned by	ě	Diabetes Mel		, doda, , <b>, , ,</b> , , , , ,	or roodining	in the con-	conying occors	givorini				_	oly 4 🗸 Unknown
duire quire uld be	ted								_	24a. Was a			psy findings available
aw re	흷									autops	y pr	ior to cor	npletion of cause of
Recc The lavicate has	Completed									1 Yes 2		eath? ✔ Yes	2 No
Division of Vital Records, P.O. Box 68  Hospital or Attending Physician: The law requires that the death certif 24 hours after death.  Funeral Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use as	Be	25. Was case referred to medical examiner?	Hospital:				26.Place	of Death (	Check onl	y one)			
Physical Phy	2	1 ✓ Yes 2 No	<u> </u>	npatient 2		•					Residence 6		
ding Pl		27. Manner of Death  1 X Natural 5 Dead		of Injury , Day,Year)	28b. T	ime of Inju		ry at Work?		d. Describe h	ow injury occurre	d	
SiOI vitten death ctor:	훘	= 5 Pend	tigation					Yes 2	7- 15				
Division tal or Attendi rs after death. al Director: A	Certification:		not be	e of Injury - A	t home, fai	m, street,	factory, office b	ouilding, etc	28	If. Location (St or Town, St		r or Rura	Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director:	3	29a Certifier	mined (Specify)										
To the Ho within 24 h To the Fu completely	Medical	(Check only	ysician: To the bes niner:On the basis o										
To the within 2 To the complet	Jed -	29b. Signature and title of certifier	and manner s			vestigatio			alled at ti	T Inne, date a			
		255. Signature and title of certifier	/			0	29c. Licens				29d. Date signed	•	
		MIC			M	)/	0.C.I	IVI.⊏.			December 9	, 2010 	
	ſ	30 Name and address of person	1		,	111	lana Ct	D-W-		24204			
		Rússell Alexander MD.	Assistant-M			1111	enn Street,	Baitimo	re, MD	21201			
St Regist		31. Date filed (Month, Day, Year) <b>DEC 1 4</b> 2010	32. Re	gistrar's Sign	ature	1							
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amended items 10E & 19B/12-15-2010/wchd/map Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Edward C. Truitt /Medical 3010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funeral 265-98-7534 Yrs. Director 6-22-1952 Flordia Usual Residence of Decedent 10a. State show 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be intiffied. Director 1 □Yes 2 No DE Sussex Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10325 Carey Street 10125 Cherry Street 19956 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Well Driller Well Drilling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Truitt မ June Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Truitt (Wife) 103255 Carey Stst Laurel, De. 19956 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State Odd Fellows Cem. 4 Donation 5 Other (Specify) 12-6-2010 Laurel, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West Street Hannigan, Short, Disharoon F.H. Laurel, De. 19956 Hannigan 23a. Part1. Enter the disease, or complications that caused the heath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart indure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to initial accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Duri to for as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) physician the burial Box 68760. Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) P.O. ned by the a detached f ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ sign be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate 2 🗆 No 1 ∐Yes 2 No 1 ☐ Yes or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 TyNo 1 ☑ Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00010 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRIDERVILLE CHAN 899 REDDEM 31. Date filed (Month, Day, 32. Registrar's Signature Year) State U Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Tris F. Trescott 2010 6:51 Рм December Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death
Westminster 4c. County of Death **Examiner** Carroll Hospital Center Carroll 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Dec • 31 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 248-44-4072 1 M 2 X F 84 Months Davs Hours fforida Director 1925 Dec. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d, Inside City Limits Director Maryland Carroll Finksburg 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21048 1493 Rack Point Dr. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married ģ 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Own Home Homemaker n and Mental Hygien 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Tillman Fairey, Sr. Bessie Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1493 Rack Point Dr., Finksburg, MD 21048 1 and 2 s of Health item 27 Edward B. Trescott/Husband other Baltimore, 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or oth 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Carroll Cremation Inc. 12/08/2010 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2Practisa Ganeral Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician ue to (or is a consequence of): disease or condition resulting in death) 100 Medical Due to (or Examiner nurenegrun Sequentially list conditions. Examine if any, leading to immediate

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Cause (Disease or linjury consequence of that the death certificate be executed physician and the burial-transit notical a that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 ■ 9 ☐ Unknown detached 9 Unknown P.O. þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mathemerem Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) No No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowled 2 Medical Examinar: On the base of examination 3 Certifying Nurse Practionary to the best of my 29a, Certifiei ocured at the time, date and place, and due to the cause(s) and manner as stated. or injection at the time, date and place, and due to the cause(s) and manner as attending a control of the cause(s) and manner stated.

Who ge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) WSL 037949 30. Name and address of person 23a) (Type, Print) w-Box Jac

State Registrar 31. Date filed (Month, Day, Year)
DEC 0 8

32. Registrar's S

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 26 per DVR G911 1/14/11 dk
State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOVEMBER FRANK ALDRED TARBUTTON 2010 2:40 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HEARTFIELD ASSISTED LIVING EASTON TALBOT 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 1 **X**M 2 □ F Min. Days Hours 09/16/1921 89 Director 219-03-4018 Usual Residence of Decedent 28a-f shov 10a. State 10b. County death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD KENT CHESTERTOWN 1 X Yes 2 No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 25704 COLLINS AVENUE UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene.
Important: If item 27 is marked any injury or Att. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) VOCATIONAL Elementary/Seconday (0-12) College (1-4 or 5+) **EDUCATION** REHABILITATION SUPERVISOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ FRANK TARBUTTON PAULINE WALLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POLLY TARBUTTON/DAUGHTER 102 RESIN DRIVE, CHESTERTOWN, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SUDLERSVILLE CEMETERY 12/05/2010 SUDLERSVILLE, MD of Euneral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. SPEER ROAD, CHESTERTOWN, MD 21620 Part 1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Dody disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or linjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 2 No 9 Unknown g Unknown certificate has been signed by t rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No Yes 1 Yes 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Assisted Hospital: 1 ☐ Yes 2 ☑ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA eral Director; After thi filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Hem 23a) (Type, Print)
CLNP-8579 Commend on #106 EASTON, MD 2164 1 8 elean 31. Date filed (Month, Day, Year State

Registrar

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				State of Marylan				-	_	
State of Maryland / Department of Health and Mental Hygiene [ ]   ]   [										41244
	Physicia Medic		1. Decedent's Name (First, Middle, Last) FELICITAS B TUBER,					2. Date of Deat Month		3. Time of Death  6 1 Sp M
, cont.	Examin		4a. Facility Name (if not institution, give street and number)  Howard was unby Hospitm 4b. City, To				Location of Death	amp	4c. County of Dea	ard
	Funeral Director  5. Social Security Number 214-41-7084  Usual Residence of Decedent  7. Age (In yrs. last birth 1 M 2 🔀 F 7 2					If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 3 106 7 1	9. Bi	rthplace (State or Foreign Dispring) Tippines
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	10a. State 10b. County 10c. City, Town or Lo							
			10e. Street and Number 6334 Cedar Lane			10f. Zip Code 21044		1	10g. Citizen of What Country? USA	
9800			11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates.		l I	<ul> <li>13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> <li>1 □ Yes 2 ☒ No Specify:</li> </ul>			14. Race - American Indian, Black, White, etc. Specify: Asian	
1215-(			(Specify only highest grade completed) ((Callege (1-4 or 5+)			Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  ursing assistant			16b. Kind of Business Industry  Elder care	
Baltimore, Maryland 21215-0036			17. Father's Name (First, Middle, Last) Aurelio Baclig			sing as	18. Mother's Name (First, Middle, Maiden Surnai Serela Salazar			care
, Mary			19a. Informant's Name/Relationship (Type, Print)  Butch Tubera/Son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  P.O.Box 1002 Keller, Texas 76244						' '	
imore			20a. Method of Disposition  1 XBurial 2 Cremation 3 [ 4 Donation 5 Other (Spec	Remo@al from State	emetery cren Dakla	sition (Name of natory or other place Wn Ceme	tery 11/	24/201		more,Md
Balt	permit. Depart Import any inj		21. Signature uneral Strvice Linear	Hend	P4 9	HMandan PAda 241 Colu	sREMALDI umbia Bl	FUNER vd.Sil	AL SERVI ver Spri	CE,P.A. ng,Md20910
	mysician/ Medical	6	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Approximate Interval Between Onset and Death							
-	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-theory.	al Examiner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):  Due to (or as a consequence of):						
			Cause. Enter Unicertying Cause (Disease or iinjury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):							
200		edica	d							
. Box 6876		Certificate: To Be Completed by Physician/	IF FEMALE:   23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1							
Division of Vital Records, P.O.			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   X   No 3   Probably 4   Unknown							
cord			24a. Was an autopsy findings avait prior to completion of cause death?					completion of cause of		
al Re			End Stace Renal Discrese: Dialysis Dependent; Acute Respiratory Failure 1 Wes 2 No 1 Wes 2 No 1 Wes 2 No 25. Was case referred to medical examiner?							
₹			Q 1 ☐ Yes 2 XNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)							cify)
on o			27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be							
Divis			4  Homicide determined	building, etc. (Specify	building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		Medical	29a. Certifier  (Check only one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)							
0	2		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  11 (9) 0							
_			30. Name and address of person who	Mujahidm	0	Print) 5755 Howa	Cedar L	ane Co	lumbia.M	d/23944 tal
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month Chi Khiem Tran December 6, 1:40 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth
(Month Day Year)
Jan. 1, 1920 6. Sex 9. Birthplace (State or Foreign Country)

Vietnam 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Director 586-28-9341 90 Yrs. Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Germantown 1 🗌 Yes 2 🖵 No 10e, Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 17405 King James Way, Apt. 102 20874 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iten I Examiner ı Black, White, etc. Š 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Asian Specify: "natural" Completed 3 
Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Owner Own Business of Health and Mental Hygi If item 27 is marked other or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ should be Trung Tam Tran Nghia Nhu La 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phuong Tran Luu/Wife 17405 King James Way, #102, Germantown, MD 20874 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State etropolitan Crematory Dec. 11, 2010 Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 Vrs Immediate Cause (Final Physician/ disease or condition resulting in death) End-Stage Dementia Medical Due to (or as a consequence of) Examiner 6 mosAnorexia Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury e attending physician and 2 yrs that the death certificate be executed Chronic Kidney Failure that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K No has 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: M Nursing Home 5 Residence 6 Other (Specify 2 🕇 No 1 Yes ပ္ 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. work?
1 \[ \text{Yes} 2 \[ \text{No} \] 1 Natural 2 Accident 3 Suicide injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined Cify or Town, State) Medical 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) December 7, 2010 D50612 person who completed cause of death (Item 23a) (Type, Print) 3305 N. Leisure World Blvd., Silver Spring, MD 20906 Samuel G. Maller, Md 31. Date filed (Month, Day, Year) Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kamona 0310AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Peninsula Regional Medical *Micomic* <u> XIIISburl</u> Cento 6. Sex 1 ☐ M 2 🗹 F 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months **Director** 3-99-4089 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County Wicomico Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1-Yes 2 No U.S.A 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2180 Senior Jack Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Never Married 2 Married ☐ Yes 2 No 1 Yes 2 🗆 No Yes, Give Specify: Puerto Rican 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RADAUGHTAL 0 AQ Pi Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If Ite 1 Burial 2 Cremation 3 Removal from State Hill 4 ☐ Donation 5 ☐ Other (Specify) 917 W. Isaballa any in 22. Name and Address of Facility Maryland art 1. Enter the disease, or comblication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Matural 2 Accident
3 Suicide
4 Homicide within 24 hours after death.

To the Funeral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10 1 mg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 State anna Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year 10:00 A Delia Beatriz Victoria Dec 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Argentina 8. Date of Birth **Funeral** (Month, Day, Ye Days 1 □ M 2 🔀 F Months Hours Min Year) 65 Yrs. **Director** 215-19-2722 Jan. 1945 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖾 No NY Queens Forest Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 9944 67th Road United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

— Central Black. White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: If Yes, Give Hygiene. other than "natural", Specify: Hispanic 3 Widowed 4 Divorced Completed Year or Dates. American the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Physicist Management Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager pernit. Page 1 and 2 should be filed wind Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event; marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Virgilio Victoria Mireya Troncoso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria J. Fanjul, Daughter 10557 Englishman Drive, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Durial 2 Cremation 3 Removal from State Ft.Lincoln Crematory 12/4/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland M01102 21. Signature of Funeral Service Doenses 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death T Cell Lymphoma Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imiury and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown the detached 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed ! 23e. Did tobacco use contribute to the cause of death? þ filled in by the funeral director, page 2 should be 1 Tes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 🕱 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural
2 Accider 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. the 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 일 29c. License number 29d. Date signed (Month, Day, Year) R120698 12/4/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd., Rockville, MD 20855 Nicole Christenson CRNP 31. Date filed (*Month, Day, Year*) **DEC 0 9 2010** State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U | U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician/ 11:54 P<sup>M</sup> Jose Miguel Vega 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday) Funeral Days Hours Country) 1 ፟ M 2 ☐ F DC 61 1949 Director 579-62-1605 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 □ No DC Washington None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20002 2105 I St. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates.1970-1976 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Rlack White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: Cuba-American Cuban 1 X Yes 2 □ No Specify: Cuban 3 Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry 2 should be filed w...
"the and Mental Hygiene.
"the other than "r."
" the Mer (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Downtown DC Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vermit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic even ျ Cela Vega De la Rosa Mario Vega 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 P St. SW #802 Washington, DC 20024 Constance Ann Vega/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 12/09/2010 Washington, DC 4 Donation 5 Other (Specify) Glenwood Cemetery Signature of Funeral Service Lice 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multi Organ Failure disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Fungemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of Cirrhosis attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown certificate has been signed by the a rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩mknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 1 the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be **Division of Vital** Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 🗌 Yes မြ ER/Outpatient 3 DOA 1 🛮 Inpatient 2 🗆 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

State

29b, Signature and title of certifier

31. Date filed (Month, Day, Year)

Babak Salehi Pirouz

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

legistrar's Signat

8600 Old Georgetown Rd. Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Cember Physician/ 0 Medical 4a. Facility Name (if not institution give street and number) 4c. County of Death Examiner 7/M 0 Baltimore NX lec Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday 6. Sex **Funeral** Days 3/5/1962 1 □ M 2 💢 F Hagerstown, MD 220-78-5396 **Director** 48 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes X No Washington Cascade 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral US 14310 Pen Mar-High Rock Rd. 21719 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: white Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Doris Isabel Emory John Ordean Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14310 Pen Mar-High Rock Rd. Box 81 Cascade, MD 21719 Daniel G. Wiley, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Bethel Church Cem. 1 Burial 2 Cremation 3 Removal from State 12/23/2010 Cascade, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc 21. Signature of Fund I Service Lice Broad St. Waynesboro, PA 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury to (or as a consequence of) To the Hospitallor Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🚣 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 Yes 2 No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 A Natural 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number 104 ne and address of person who completed cause of death (Item 23a) (Type, Print YA TISONAC ST PAU 345 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year REBECCA WACHTER DECEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Date of \_ (Month, Day, 1 🗆 M 2 🕱 F Year) 1925 Months Days Min. 216-22-9047 Director 85 Maryland June Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marla Hyglene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 7561 Sundays Lane 21702 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk.) ဂ Frank S. Tinney Lillian R. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6306 Old National Pike, Boonsboro, MD 21713 Margaret Cahill / Daughter 20b. Place of Disposition (Name of competer), crematory or other place)
REST haven
Memorial Gardens 20a. Method of Disposition Date 18, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Dec. 2010 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
b Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 pg Unknown 2 💢 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performed 1 ☐ Yes 2 🗷 No Division of Vital the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ပ 1 X Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 🗌 Pending work? 1 Yes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Moun 58808 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rusu Frederick, mo 21701 Florin 400 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Wilma Loraine Weltz 12 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Charlestown Retirement Community Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex **Funeral** Days (Month, Day, Year) 6/26/1931 Hours Min. 1 M 2 S Director 579-42-4541 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director MD Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 709 Maiden Choice Ln. RGS124 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ales Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Paul Theodore Weltz Ethel F. Houpt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kimberly Gould / Cousin 1502 Seminole Ln., Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Washington Nat'l Cem. 12/14/2010 Suitland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc of Funeral Service Licensee M01411 4112 Old Columbia Pike, Ellicott City, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition ; Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Pregnant at time of death 5 Other (specify) Month signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2-No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) un v ano

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month

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32. Registrar's Signature

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2010

Country)

White

3. Time of Death

8:00

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

MD 21043

Interval Between Onset and Death

Day

1 ☐ Yes 2 ☐ No

Year

PA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Dayo 20°0 Anna Catherine Wine 9:35 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Williamsport Nursing Home Williamsport Washington Social Security Number 8. Date of Birth

July 22,1916 Funeral 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 X 94 Maryland **Director** 217-12-2753 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Washington Williamsport 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 154 North Artizan Street 21795 USA death \ 12. Was Decedent Ever in U.S. Armed Forces?
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If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō ģ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 Yes 2XXNo Specify. "natural", Specify: Completed 3 XXWidowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Belle Young Harry William Krotzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Albert Wine- Son 231 Maplehurst Ave. Williamsport, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Riverview Cemeterv Dec.14,2010 Williamsport, Maryland Signature of Puneral Service Licensee sborned Afuneradity Home, P.A. anyi 425 S. Conococheague St. Williamsport, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Physician: The law requires that the death certificate be Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 0063233 201 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) SH-0 580 Haccontown Mi) hmoso 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 14 Registrar

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State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month Year OPAL L. WERNER 0:15 PM DEC Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL LUTHERAN MONTGOMERY HOME ROCKVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** AUG · I , 1916 Days Hours 1 🗆 M 2 🗓 F 508-03-3722 NEBRASKA Director 94 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MONTGOMERY MD. ROCKVILLE 1 H Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9701 VEIRS DRIVE 20850 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OFFICE MANAGER CHURCH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ HENRY W. WERNER ANNA POEHLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK McGOVERN -EXECUTOR 9701 VEIRS DRIVE, ROCKVILLE, MD. 20850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
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28. Name and Address of Facility 21. Signature of Funeral Service Ucensee HYSONG 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition WY Medical resulting in death) Due to (or as a consequence of) **Examiner** NUREXIA Sequentially list conditions, Examiner Due to (or as a consequence or). if a y, leading to him ediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown Month Year Pregnant at time of death the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred s after death. 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation the 1 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Funeral L Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie within 2 29b. Signature and title of certifier 29c. License number Medu ans M.D 00057158 2010 CLUMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9701 VEINS D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mont Dec. 2010 7:00 Рм Mattanee Washirapunya Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 - M 2XXF Months Days Hours Min March Day <sup>Year</sup>1952 That Land 58 Director 215-94-0301 Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director Rockville MD Montgomery 1 Yes 2XXNo 10e, Street and Number 10f. Zip Code P 10g. Citizen of What Country? Examiner must be Funeral 23a USA 20855 17116 Flatwood Dr. items ? 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ò 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Asian 'natural", 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 Is and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Unobtainable Somsak Udomsombatmeechai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17116 Flatwood Dr., Rockville, MD 20855 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Itthikul Washirapunya - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial Cremation 3 Removal from State 4 Donation 12/12/10 Alexandria, VA Everly Crematory 5 Other (Specify) 21. Signat of uneral Service Scenses 22. Name and Address of Facility Everly-Wheatley, 1500 W. Braddock Rd Alexandria VA MO1453 Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Metastatic Colon Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 s been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant a Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE မြ 1 Inpatient 2 ER/Outpatient 3 DOA After this 24 hours after death.
Funeral Director: After thi eted filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No injury 1 X Natural Accident Investigation Acciden Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hou

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completed fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12/5/2010 R120698 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Nicole Christenson CRNP 60001 Muncaster Mill Road, Rockville MD 20855

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State Registra/Amend#26.PerPhys.POC12-10-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DEC. 2010 **Physician** ELEANOR WILLIAMS 5 2:25AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. BOWIE ARK ASSISTED LIVING If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 □ M 2 🔀 F 82 579 38 5270 JULY 28 1928 MD. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 ☐ No Director P.G. UPPER MARLBORO MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20772 12223 WESTVIEW DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: BLACK þ 3X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) RETAIL PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HATTIE JONES ROGERS BURRELL ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12223 WESTVIEW DR. UPPER MARLBORO, MD 20772 MICHAEL WILLIAMS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 12/9/10 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State SUITLAND, MD WASH. NAT. CEM 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 20010 WATSON F H 3435 14th ST N.W. WASH. DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) norths Schenic (ANDIOMODATE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 18 months? Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Miscore 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home Assisted 6 Mother (Specify) Assisted 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 28b. Time of Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760. P.0. Division or Vital Records,

requires that the death certificate be executed

**Funeral** 

Director

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

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Department of Health a Important: If item 27 is any injury or other tra once,

**Physician** 

/Medical

Examiner

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funeral

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29a. Certifier (Check only one)

Pages 1 and 2 should be nent of Health and Mental

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

page 2 s certificate this / fter or Attending death within 24 hours after death To the Funeral Tirector: completely filled in by the f Hospital

and title of of 29c. License number 29b. Signa 052261 n who completed cause of death (Item 23a) (Type, Print) ( Anhon 8116 Good Cock ma PILLAMO 32. Registra 's Signature 31. Date filed (Month, Day, Year) State DEC 1 0 2010 Registrar

Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Julia Ann Wilson Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** hu 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 ☐ M 2🛣 F Months Days 5/24/1923 Wash. DC 87 579-26-5045 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City. Town or Location Director 1 Yes 2 No Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ÜSA 21811 22 Carnegie Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc 1 Never Married 2 Married Specify: white Completed by  $\int \mu |\mu| W_i / S d M$  Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No 3¥ Widowed 4 ☐ Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alma McKeever Willard Warthen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Carnegie Place Berlin, MD 21811 Jane Kelley (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State First State Crematory 12/8/2010 Millsboro, DE 4 Donation 5 Other (Specify) 21. Signature of Fune of Service Licenses 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MATASTATIC disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 9 Unknown 9 Unknowh as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/ No 3 Probably Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion a cause of 24a. Was an certificate has autopsy page death? Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 14 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier DO05 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 030 p 31. Date filed (Month, Day, Registrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year Sarah Morriss Weant 7:05 P M Medical December 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll County Fairhaven Svkesville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth Funeral 6. Sex 7. Age (In vrs. last hirthday) Days 1 M 2 F Hours 87 218-24-7589 Director 13.1923 Virginia Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d Inside City Limits Director must be notified Carroll County Sykesville Maryland 1 Yes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral United States 21784 7200 Third Avenue death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black White etc "natural", or 1 Never Married 2 Married δ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Sarah Tripplet Charles Morriss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5010 30th Street North Arlington, VA 22207 19a. Informant's Name/Relationship (Type, Print) Edward O. Weant, III / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or 12/6/2010 | Hampstead, Maryland 21. Signature of Funeral Service License M01072 22. Name and Address of Facility Eline Funeral Home 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 5 mall cell carunoma Non disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day 1 Yes 2 9 Unknown is been signed by the should be detached Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ myelocytic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? nypertension 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No certificate 2 N 1 Yes 25. Was case referred to medical examiner? Hospital or Attending Physician: funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide work?
1 Yes 2 No To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number December 2 2010 D34849 WJL

State Registrar

Box 68760

P.O.

Records,

**Division of Vital** 

DHMH 17 Rev 7/2009

Rd Eldersburg MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

1645

32. Registrar's Signature

illiamian

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 6, Day 2010 Lempi L. Wickline 11:15 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Spring House Assisted Living Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) WI 1 □ M 2**X** F Nov. 24, 1914 Months 217-44-0060 Director 96 Usual Residence of Decedent show with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 🗌 Yes 2 🎦 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2201 Colston Drive, #T101 20910 TISA 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes No Specify. If Yes, Give Specify White 3 X Widowed 4 ☐ Divorced Completed Year or Dates Hygiene. other than "natura rent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the traumatic event, the Program Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elias Louma Jennie Erickson permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll John Andre/P.O.A. 14320 Blackmon Drive, Rockville, MD 20853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Parklawn Memorial Park 4 Donation 5 Other (Specify) Rockville, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
Collins Funeral Home Inc.
Solver Spring, 21. Signature of Funeral Service Licensee 500 University Blvd. W., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ Atherosclerotic Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Dav Year signed by the a d be detached f 1 ☐ Yes ∠-e 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation, Chronic Obstructive Lung Disease, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Failure to Thrive page 2 s autopsy performed? Yes 2 No death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Assisted Living Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify Certificate: To 1 Tes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28656 December 7, 2010

Registrar
DHMH 17 Rev 7/2009

State

Registrar's Signature

15245 Shady Grove Road, #130, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ravi Passi, MD

31. Date filed (Month, Day, Year)

DEC

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1450 Arnold Hans Weiss December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Germany 1 🗓 M 2 🗆 F July 25 Months Days Hours Min. 86 **Director** 396-14-7807 Usual Residence of Decedent should be filed within 72 row...
I and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-1 srow...
I went, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 3811 Woodbine Street 20815 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Lawyer any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Teckla Rosenberg Stephen Wangerscheim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Memit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 5405 Golf Lane, N. Bethesda. Maryland 20852 Daniel L. Weiss - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lincoln Crematory 12/13/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904  $\mathcal{O}$ 23a. Part 1. Enter the disea e shock, or heart failure. omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death one cause on each line Immediate Cause (Final .Physician/ disease or condition resulting in death) Medical Due to (or as a c Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a cons Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Year Pregnant at time of death 4 Pregnant 9 Unknown been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No this certificate 2 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Tes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 Pending injury work? 24 hours after death.

Funeral Director: Al 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be To the Hospital or Atter within 24 hours after de To the Funeral Director completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cattying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tile of 29d. Date signed (Month, Day, Year) 0057574 15+1 December 08. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Ahmed Heshmat.

31. Date filed (Month, Day, Year,

DEC

M.D.

10 2010

32. Registrar's Simature

Box 68760

P.O.

Division of Vital

10301 Georgia Avenue, #203, Silver Spring, Maryland 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 1:50p M Walter Franklin Wallick 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Renaissance Gardens - Riderwood Prince George's Silver Spring Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 10/02/1923 1 💹 M 2 🗆 F Months Days Hours Min. Director 292-14-9476 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 20904 U.S.A. 3112 Gracefield Road, filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. tant: If item 27 is marked other that ury or other traumatic event, the N Writer-Editor United Auto Workers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Walter Wallick Kathrun Blocher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #T20, Silver Spring, MD 20904 Ruth Wallick - Spouse 3112 Gracefield Road. Department of Health Important: If item 2 any injury or other tonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 🗷 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Lincoln Crematory 12/14/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 21. Signature of Funeral Service Licensee X Www 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ End Stage Renal Disease disease or condition Medical resulting in death) Examiner Diabetes Mellitus Esquentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) signed by the attending physician and I'm be detached for use as the burial ransit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month 2 No 9 Unknown page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 🗌 Yes 2 🗆 No 1 ☐ Yes 2 🔽 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🛛 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 🗌 Yes 2 🔲 No 1 X Natural 5 Pending s after death.

I Director: Aff
d in by the fur Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) 24 hours a Medical 29a. Certifler Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 😿 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 10 1126

Registrar

State

3110 Gracefield Road, Silver Spring, Maryland 20904

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

CRNP.

Registrar's Signature

Julaine Harding,

1 0 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 12, 2010 KENNETH ROBERT ZIMMERMAN 1:00 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9507 Liberty Road Mt. Pleasant Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1√ M 2 F Months Days Hours D. C. Director 550-36-8059 Usual Residence of Decedent 28a-f shor 10a. State items 23a or 28a-f sho ler must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ₹ Yes 2 ☐ No Maryland Frederick Mt. Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9507 Liberty Road 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Korea 1 ☐ Yes 2 🕅 No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Coppersmith U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked of ၉ Byron Lewis Zimmerman Sara Catherine Leitch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 slument of Health a tant: If item 27 is 9507 Liberty Road, Mt. Pleasant, MD 21701 Agnes V. Zimmerman / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) ō permit. Page Department of Important: If any injury or Smithsburg Crematory 12/14/2010 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Eacility & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 23a. Part 1. Enter the disease. replications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ signed by the atte in the past 12 months? Day Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director. After this certificate h completed filled in by the funeral director, page 2 No Yes 2 No 1 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Hospital: Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending work' 2 No 1 Yes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of

State Registrar

P.O.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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towler

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 30 2010 Physician/ liadoro Month 6:00PM December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore Social Security Number If Under 8. Date of Birth 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Date of Direct (Month, Day, 11ne 23 Months Days Hours 1 X M 2 D F Min Philippines Director 575-87-1772 Yrs 63 June Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must ham matter and 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 X No Owings Mills, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Sara Court Philippines 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Completed Asian 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Military 4 Officer Military Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Calixto Agbayani Agbayani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Violeta Agbayani Sara Court Owings Mills, MD 21117 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Marede, Santa Anna 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/10/2011 Marede Cemetery Cagayan, Philippines Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Liver lancer · Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or impury that initiated events Examine Due to (or as a consequence of) ohysician and the burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Year Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? ours after death.

eral Director: After this certificate I filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 2 4 N Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 6 Mother (Specify) thospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

nskijapalne M.D

NS Rajapakse, M.D.

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DOUS 7 465

2835 Smith Av. 5-203, Baltimore, MD. 21209

12/30/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000 1000 1264 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Maria, Erlinda, Almogela Physician/ Month 10:19 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 22 South Green University of Maryland Medical Center Baltimore street Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) April 2, 1931 Days 1 □ M 2 🗓 F Months Hours Min. Philippines Director 352-34-2375 79 Usual Residence of Decedent or 28a-f shov 10a, State 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 ☐ Yes 2 🔀 No Baltimore Pikesville 10e, Street and Number 10a, Citizen of What Country? Funeral 8945 Griffin Way 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Medical Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andres Kimwell Luisa Gaerlan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martino Almogela Husband 8945 Griffin Way, Pikesville, MD 21208 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Family Cemetery 1/3/2011 Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Le hos Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Life to for as a conse vience of Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Myocardial Infarction To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \( \triangle \text{ Nursing Home } 5 \) Residence 6 \( \triangle \text{ Other (Specify)} \) 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🔲 Yes 2 🗌 No Accident Suicide Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) shlyxinder, MD 30+h 1982920476 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21201 22 South Greene Street Ashley Kinder 31. Date filed (Month, Pa 32. Registrar's Signature State Registrar

X DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ashbrook Ray Lee 2010 December 8:06 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 9301 Cabbage Run Road Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months (Month, Day, Yea ept. 21, Hours Director 213-80-1438 49 Sept. Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9301 Cabbage Run Road 21701 U.S.A death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 🗌 Never Married 2 🙀 Married "natural", or þ 1 X Yes 2 ☐ No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates. 1979–82 White the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 t of Health and Mental Hygiene. If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) HVAC installation manager **HVAC** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard L. Ashbrook Wanda B. Snodderly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra L. Ashbrook/ wife 9301 Cabbage Run Rd. Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 and Department of Important: If ite any injury or ot 1 Burial 2 Tremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation 12/31/2010 Sykesville, MD 21. Signal of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home Stomus 11802 Liberty Rd. LIbertytown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SQUAMOUS CELL LUNG CANCES Physician/ disease or condition MENTHS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 5 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA n 24 hours after death.

ne Funeral Director: After the pleted filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work's Investigation
6 Could not be 1 Yes 2 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner To the best of my knowledge, death promod at the line, date and place, and due to the cause(e) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 131761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOL W. SEVENTH-ST. 32. Registrar's S State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ABERTS NINA MYR D 234M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospital Center Westminster 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖵 F Months Hours (Month, Day, Year) 12/22/1914 NC. 96 **Director** 214-34-4581 Jsual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll MD Manchester 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3353 N. Main Street 21102 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: white Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 721 and Mental Hygiene.
7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) sewing factory seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thurmond Calvin Cox Bertie Jane Blevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2827 Rohrbaugh Road, Hampstead, Md. 21074 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Luther C. Aberts, son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/30/2010 Finksburg, Md. Evergreen Memorial Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00741 Lhemmer 934 S. Main St., Hampstead, Md. 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner SEVERE Sequentially list conditions, if any leading to translate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): inding physician a use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter for u in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Ven Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? After this certificate 2 No 2 1 N 25. Was case referred to medical To Be 26. Place of Death (Check only one, examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier (Type, Print) Bast Main Sheet Westminster MD 21157 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) MUZMN 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar

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		•	For State Registrar	Otate of Mai	ylaria /	•	ficate of D		vicinairiy	Reg. No			
		1. Decedent's Name (First, Middle, Last)  2. Date of Death										3. Time of Death	
	Physicia Medic			Edmund D.	Austi	n			Month Decem	ber	28, Year 201	0 10:20 A.M	
	Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or Location of Death			4c	. County of Dear		
sol.	·		Glen Burnie Heal				n Burnie			Anne Ai			
	Funeral Director		242 20 3101		n yrs. last bir 37		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	. 8. Date of Bir (Month, Da 02/15	th y, Year) 0/19:	9. Bir 23 No	thplace (State or Foreign orth Carolina	
	nd <b>how</b> at	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location											
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	or 28	Ē	10e. Street and Number				10f. Zip Code		П	10g. Ci	tizen of What Co	of What Country?	
	s 23a ust b	Funeral Director	5204 Disney Ave	enue		21225					U.S.A.		
	death item ner m	Fur	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?				s Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit		
9500-612	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. W	W II		1 ☐ Yes 2 🔼 No Specify:					White	
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מ	Hygiw Other ent, t	Be (	17. Father's Name (First, Middle, Last)			Dub	operaco	18. Mother's Nam	e (First, Middle,				
Maryland		မ		Joseph Aust	tin			Mad	e Willia	ams	,		
a Z	1 and 2 should be f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty	pe, Print)	198	b. Mailing	Address (Street a	and Number or Run	al Route Numbe	r, City or	r Town, State, Zi	p Code)	
e, E	nd 2 sealth an 27 i		Steve D. Austin	/ Son		195 W	loods Dri	ive	Annapol	is,	Marylan	d 21403	
	⊕ ೭ ≐ ๖		20a. Method of Disposition 1 → Burlal 2 → Cremation 3 →	Removal from State	cemete	ery, crema	tion (Name of tory or other place	e)	Date		ocation - City or	·	
Baitimor	t. Page 1 tment of rtant: If it		4 Donation 5 Other (Specify	)	Glen							ie, Maryland	
pa	permit. Pag Department Important: any injury o		21. Signatur of Juneral Service Licens	dridge	e	- 1	Name and Addres	· O				ce, P.A. ryland 21225	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or		e death. Do	not enter	the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between	
-	Physician	1	Immediate Cause (Final disease or condition	ACU	TE 1	1265	PIRA	TORY	FAILL	1126	=	Onset and Death	
	Medical Examiner		resulting in death)	Due to or as a co	onsequence	of):	0 112	TH 197	E15	774	CIC		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	onsequence	of:	- 00	11 151	cces	115	2/2	-	
	ted J Insit	Examiner	Cause (Disease or linjury	CITY	2011	C 1	BRONC	241775					
	execu an and ial-tra		that initiated events resulting in death) Last	Due to (or as a co	onsequence	of):	2 0 1 12						
2	ificate be executed g physician and as the burial-transit	Medical	•	d. HUP	074	-910	010						
) 20/20	ertifica ling p e as t		IF FEMALE:	23c. If yes, outcome of p	pregnancy				-				
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o o	he de y the tched	Physician/	1  Yes 2  No 9  Unknown	g 🗌 Unknown									
7. J	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completed filled in by the funeral director, page 2 should be detached for use	by	Part II. Other significant conditions of PARKINS	intributing to death but in	not resulting	in the und	lerlying cause giv	en in Part I.	23e. Did to			the cause of death?	
g	requir been s	letec	PROGRES	CIVI W	450	141	2 DET	2615	24a. Was			topsy findings available	
Records,	he law ite has	Completed	CENEBR	20 MASCO	ULA	2 2	CC/06	NT	pend		prior to death?	completion of cause of	
VItal	sian: T ertifica ctor, p	BeC	25. Was case referred to medical examiner?				-	ace of Death (Chec		2 2 10			
5	hysic this ce al dire	မ	1 ☐ Yes 2 ☑ No	Hospital:				4 Nursing H			6 Other (Spec	eify)	
n 01	ding F h. After funera	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Y		Time of injury	28c. Injury work' M 1 🗆		28d. Describe h	now injur	y occurred		
SIO	Attendr deat	rtifi	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	- At home, fa	arm, stree		res 2 LINO	28f. Location (S	Street an	id Number or Ru	ral Route Number,	
UIVISION	tal or / rs after al Dire		4 - Homicide determined	building, etc. (S	Specify)				City or Tou				
	Hospi 24 hou Funer leted fill	Medical	(Check 2 Medical Exami	ician: To the best of my ner: On the basis of exan e Practioner: To the bes	nination and/	r investig	ation, in my opinio	n, death occurred a	t the time, date a	and place	e, and due to the	cause(s) and manner stated.	
	Fo the vithin To the complete	2	29b. Signature and title of certifier	eral la	206	vieuge, de	29c. License		De, and due to th		te signed (Mont		
			A PLACED	PATALI	NET	HIC	Sn Di	18426		DE-0	EMBE	29,2010	
	'		30. Name and address of person who c	ompleted cause of deat	h (Item 23a)	(Type, Pri	nt)	1. 4. 4. 4. 4.			·		
			372/ 10TEE	1 63			MARC	GLATVD	212	25			
	Stat Registra		31. Date filed (Manth Day Year) 201	2. Registrar's	Signature	back	W.						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ TRICIA Medical Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death N/A Examiner 105 PITAL BATTIORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
1 9 4 3 MD Security Number - 40 - 0 4 3 1 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF March Day, Year 67 Yrs. **Director** Usual Residence of Decedent 28a-f show 10a. State MD 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Harford Joppa 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1919 Singer Road Funeral 21085 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. <u>ک</u> 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 72 hours after Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. Betts Funeral life. DO NOT use retired Mortician within 7 College (1-4 or 5+)
2 Yrs Elementary/Seconday (0-12) Home 12th Be 17. Father's Name (First, Middle, Last)
Leslie Eldridge permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Majden Surname) Christine Redd ၉ 19a. Informant's Name/Relationship (Type, Print)
Terri L. Betts/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6210 Hilltop Ave. Balto., MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Arbutus Mem. 1/8/2011 Arbutus, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ESO PAGEAL Onset and Death Immediate Cause (Final Ph sician/ TASTATIL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ရု 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventioning in my printed that the cause of 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH ST 31. Date filed (Month, Day, Year) 82. Registrar's Signature State

X DHMH 17 Rev 7/2009

Registrar

10-09502 Johannah Brugh

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 41269 State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		ate of Death		j. No.			
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)     Johannah Bru	_		Date of Death     Month     December	Day Year	3. Time of Death 1555 hrs		
	4a. Facility Name (if not institution, give Johns Hopkins Hospital	street and number)	4b. City, Town, or Location Baltimore	of Death	4c. County of Death N / A			
Funeral Director	5. Social Security Number 2 4 4 - 0 4 - 0 9 1 1	53	hday) If Under 1 Year If Under 1 Year Yrs. Hour			hplace (State or Foreign		
nd show any ice.	Usual Residence of Decedent  10a. State							
the Maryland a or 23a-f sh tified at once	10e. Street and Number 31 East Nor	Street and Number  31 East North Ave.  10f. Zip Code 21740  USA						
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland cent of Health and Mernal Hygiene.  To ther traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No II Yes, Give Year or Dates:	13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical  1 Yes 2 No specify	n, Puerto Ricán, etc.)	14. Race - Americ White, etc. Whi	te		
6-0036 ed within 72 hours ed within 72 hours ylgajene. other than "natun the Medical Exam Completed I	15. Decedent's Education (Specify online Elementary/Secondary (0-12)  12th	College (1-4 or 5+)	Decedent's Usual Occupation (Give during most of working life, DO NOTHOME Maker		16b. Kind of Business/Ir Home	idustry		
215-00 be filed wintal Hygie riked other ent, the M	17. Father's Name (First, Middle, Last) Robert Truma	n Harris		r's Name (First, Middle, Ma arlotte An:				
MD 21215-0036 d 2 should be filed within 7 lih and Mental Hygiene. In 27 is marked other than numatic event, the Medica To Be Comple	19a. Informant's Name/Relationship (Ty Johannah Vanatt		72 Reed Rd.AV			Zip Code)		
트 때 워크 및	20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other Specify:		of Disposition (Name of cemetery, ory or other place) I Journey	12/31/10		MD		
Balti permit. Departu Import	21. Signature of Funeral Service Licens Charisse N. Woods	M01358 per dvr	22. Name and Address of Facility 2700 Edmonds			27223		
Physician Medica examiner	23a. Part I. Enter the disease, or compli faiture. List only one cause on eac Immediate Cause (Final disease a.	h line.		cardiac or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death		
xammer	or condition resulting in death)	ue to (or as a consequence of): S Disease and Coro	evere Atheroscle	erotic Cardio	ovascular			
red I Insit Examine	cause. Enter Underlying Cause (Disease or injury that initiated c.	tue to (or as a consequence of):						
760, icate be executed sphysician and the burial - transit	d	AMENDED 23a, pt.II,	27 per me g912 2	2-4-11 vt 21	per fh			
). Box 68760, the death certificate be executed the attending physician and cirched for use as the burial - transi Physician/Medical E.	IF FEMALE: 2b. Was decedent pregnant in the past 12 months?  1 Yes 2 ✓ No 9 Unknown	23b per me  23c. If yes, outcome of pregnancy  1 Live birth  4 Pregnant at time of death  9 Unknown	Fetal death 3 Ectopi		23d. Date of delivery  Month Da	ay Year		
P.O. B. res that the de signed by the be detached find by Phy	Part II. Other significant conditions	contributing to death but not resulting			acco use contribute to the			
cords aw requi	Pulmonary Disea	noma, Hypertensi se	on, Chronic Obst	24a. Was ar autopsy perform	24b. Were auto prior to co death?	opsy findings available ompletion of cause of		
Vital Recysician: The Inscription of the Country of	25. Was case referred to medical		26.Place of Death	1 ✓ Yes 2 (Check only one)	No 1 ✓ Yes	s 2 No		
f Vital Physician: This certificated director To Be	1 ✓ Yes 2 No		utpatient 3 DOA Other	Nursing Home 5 R	3.3	Scene		
ion of tending P eath ior: After the funera	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	(Month, Day,Year)	Time of Injury 28c. Injury at Worl		w injury occurred	44-22-5		
Division of ' Division of ' ppital or Attending Ph oours after death filled in by the funeral Certification: T	3 Suicide 6 Could not b determined	28e Place of Injury - At home fa	irm, street, factory, office building, e	tc. 28f. Location (Str or Town, Sta	reet and Number or Rura tte)	al Route Number, City		
Divis  To the Hospital or A within 24 hours after To the Procesal Dire completely filled in b	one) 2 Medical Examiner:	n: To the best of my knowledge, dea On the basis of examination and/or in and manner stated.		ocurred at the time, date ar	nd place, and due to the	cause(s)		
• I	29b. Signature and title of certifier	Deed Rose	29c. License number O.C.M.E.		29d. Date signed (Mont December 11, 20			
	30. Name and address of person who $\alpha$ Victor Weedn MD JD As	ompleted cause of death (Item 23a) sistant Medical Examiner	111 Penn Street, Baltimor	e, MD 21201				
State Registrar		37. Registrar's Signature	barl					

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 0:50 BM 2010 Medical 4a. Facility Name (if not institution, give street and nur. 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Baltimore andaill stow 8. Date of Birth (Month, Day, March 1 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 - M X X F Hours Min 219-28-1967 76 Director 193<sub>4</sub> Usual Residence of Decedent shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits notified at Director 28a-fs MD Carrol1 Sykesville 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö event, the Medical Examiner must be 23a Funeral 6520 Freedom Ave. 21784 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian. Was Decedor Armed Forces? Yes XXNo Black, White, etc. 1 Never Married 2 Married 9 \$ Maryland 21215-0036 72 hours after 1 ☐ Yes XXNo Specify: 3 Widowed 4 Divorced If Yes, Give White "natural", Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene.

Is marked other tha Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown ည Howard Seifert Marie injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 6520 Freedom Ave. Sykesville, MD 21784 Joseph Blankenship / Son Baltimore, Important: If iten 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place)
Cedar Hill
Cemetery 1XXBurial 2 Cremation 3 Removal from State 1/3/11 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Fun 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ASCVD disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examin Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death signed by the a g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>율</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe 1 Yes 2 🗌 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 2 × No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. lnjury\_at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completed filled in by the funeral 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated The desired in the de 29b. Signature and title of certifie D0071045 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital, 5401 Old Court Rd, Randallobian Jonath

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month. Day

Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month a **Physician** 20:14 PM EN )Ecember 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XX 2 - F 24 April 18, 1986 AL Director 424-27-7231 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location tXX Yes 2 ☐ No Director VA Arlington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 22203 USA 4141 Henderson Apt 1111 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc Never Married 2 Married 1 Yes 2 Wo If Yes, Give XX Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 🤾 💢 No Specify: Specify: White <u>چ</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US Department of Labor 12 Economist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ William R. Bagents Laura Stegall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Lincoln St., Florence, AL 35630 William R. Bagents Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Rurial 2 ☐ Cremation 3XX Removal from State Thi-Cities Mem. Gardens Jan 1, 2011 Florence, AL 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service 22. Name and Address of Facility Gregovy Fink Fink Funeral Home, P.A. M01148 M01148 426 Crain Hwy S., Glen Burnie, MD, 21061 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disea or heart failure Approximate 23a, Parl Interval Between Onset and Death Immediate Ca 👐 (Final **Physician** Du lo (or as a consequence of): respiration disease or condition resulting in death) /Medical **Examiner** Donulniolitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Bilateral Due to (or as a consequence of): attending physician a l for use as the burial-Box 68760, Pisiress Syndrome Physician/Medical the as IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 🗌 No P.O. 9 Unknown the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 No 2 No Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Inpatient 1 ☐ Yes 2 ✓ No 2 ER/Outpatient 3 DOA P 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: neral Director: After if filled in by the funer Division or Attending 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the P within 2 29b. Signature and title of certifier 29c. License number RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Rebecca MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN U 3 2011 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Medical Examine		Laurenc							4b. 0	City, Town, or	Locat	ion of Death	Decemb	er 2	2, 2010 4c. County	of Death	0150 hrs
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5-0036 led within 72 hour Hygiene. other than "natt	$\frac{3}{5}$	17. Father's Name (F	irst, Middle,	Last)				Piigii	iee		18.Mo	ther's Name	(First, Middle				210115
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Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland department of Health and Mental Hygiene.  Important: If tiem 72 in marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must he notified at once.  To Be Completed by Elimeral Director	2	19a. Informant's Nar Josephine			Print) (Wife	)				dress (Stree			Rural Route N Co1um		r, City or Tow		
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Baltimore, vermit. Pages I ar Department of Hee important: If the njury or other tr		1 Burial 2 2 4 Donation 5	_		Removal fi	rom State		rematory or o			ry	12	-29-20	10	G1en	Bur	nie, MD
altir mit. I partme portar	ŀ	21. Signature of Fun			0		7			e and Address			tzke F	une	ral Ho	mes	Inc.
	1	23a, Part I. Enter the	M. 1	3/0	Kau	WY	doath			Twin					mbia,		21045 Approximate Interval
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	2												24a. Wa				itopsy findings available
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		25. Was case referre	ed to medica	1						26.Place	of De	eath (Check		s 2 🔻	No 1	Ye	es 2 No
Sion of Vital   Attending Physician: dean: After this certif by the funeral director,	ă١	examiner?	No No	-	pital: 1	Inpatient	2	ER/Outpatier	nt 3	DOA	Other	4 Nursin	ng Home 5	Re	sidence 6	<b>/</b> Other	r: Scene
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Division tal or Attendi rs after death. Tal Director: /		2 Accident		stigation	28e Plac	re of Injury	- At ho	ome, farm, stre	eet fa				28f. Location	(Stre	et and Numb	er or Ru	ıral Route Number, City
Division o pptal or Attending ours after death. neral Director: After filled in by the fune		3 Suicide 4 Homicide		d not be mined	(Specify)			,,	,			gi	or Town				
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To witi	Ě	29b. Signature and t	itle of certifie		id manner s	stated.				29c. Licens	se num	ber		25	9d. Date sign	ed (Mo	nth, Day, Year)
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	ļ	30. Name and addre	•						Don	n Street, E	~افاد	ore MD	21201		•		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 22. 3. Time of Death **Physician** 5:15 A M December 2010 William Peter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Howard The Lighthouse Ellicott City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05–06–1928 **Funeral** 1 ₩ 2 □ F Months Days Hours 82 148-22-7900 Pennsylvania Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. Heafth and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "hadical Examinar must be notified at Director XXYes 2 ☐ No MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10112 Spring Thaw Court 21042 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 **Kx**es 2 □ No If Yes, Give Year or Dates: Korean 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ∐ Yes 2√ XNo Specify. ₽ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Peter William Berges Bessie Yumis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau George Berges - son 10112 Spring Thaw Court, Ellicott City, MD 21042 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park | 12-28-2010 | Elkridge, Maryland 21. Signature of Funeral Service L 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc, 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherosclerotic Cardiovascular Disease Years resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia 2 yrs. Sequentially list conditions, if at y, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4XXUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy page perform certificate 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Living Assisted 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 29c. License number 2010

State Registrar Charu Mehta, MD, 8775 Cloudleap Ct., NO. 224, Columbia, Maryland 21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

31. Date filed (Month, Day, Year)

JAN 03

D34974

10-09072 Andrew C. Butler

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 10 4 27 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.	
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Anoth  Day  Year	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 6225 York Road Apt. 215  4c. County of Death Baltimore	
Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 M 2 F 69 Yrs.  7. Age (In yrs. last birthday)  1 Months Days Hours Min.  1 June 18, 1941  Foreign  Country) Max	tate or aryland
any	F	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Insi	de City Limits
<b>*</b> ,	۱	MD Baltimore 1 K Y	es 2 No
the Maryland is or 28a-f show tiffed at once.	Director		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 33a or 28a-f sho injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian White, etc.	n, Black,
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21215-0036 July be filed within 7. Mental Hygiene. marked other than it event, the Medical			
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ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati	-	Anthony Butler/brother 4418 York Road Baltimore, MD 21212  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, Sta	ate
Baltimore, bermit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place)	
Baltimo permit. Pages Department o Important: I	ł	21. Signature of Fan Connective in state  21. Signature of Fan Connective Wade, Director State Anatomy Board 655 W. Baltimore Street	et
- A	- 1	Baltimore, MD 21201	imate Interval
Physician Medical	-	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease	en Onset and Death
Examiner	-	or condition resulting in death)  Due to (or as a consequence of):	
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	-
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Box 68' e death certifi the attending ed for use as	sician	1 Yes 2 No 9 Unknown 9 Unknown	
D. He trithe d ached	튑	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause	of death?
Division of Vital Records, P.O spital or Attending Physician: The law requires that thous after death.  neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detac	d by	Obese 1 Yes 2 No 3 Probably 4	Unknown
ords w requ as been	Completed	24a. Was an autopsy find prior to completion	
Rec The la Tre la icate h	8	performed? death? 1  Yes 2 ✓ No 1 Yes	2 No
lital sician:	8	25. Was case referred to medical examiner? Hospital:	
of V ng Phy After th	입	27 Mapper of Death 280 Date of Injury 29b. Time of Injury 29c. Injury at Work 2 28d. Describe how injury occurred	
Sion Attendia death. ctor: A	Įġ.	1 V Natural 5 Pending 2 Accident Investigation 1 Yes 2 No	
Divis	Certification:	3 Suicide 6 Could not be determined Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route or Town, State)	Number, City
Hospital 24 hours Funeral fely filled	ا ا	4 Homicide  2ga. Certifier  (Speciny)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To the How within 24 h To the Fur	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s and manner stated.	
	Σ	29b. Signature and title of-certifier  29c. License number  29d. Date signed (Month, Day, V	rear)
	-	30. Name and address of person who completed cause of death (Item 23a)	
		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta Regist	ate rar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Deum bes Physician/ William Baron 2:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 X M 2 D F Days Hours 05/2671922 88 Director 218-18-0753 OH Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2XXNo MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7504 SHELOWOOD ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed Specify: 3 Divorced 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 OWNER HEADWEAR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SAMUEL BARON BESSIE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CELESTE BARON/WIFE 7504 SHELOWOOD ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
RLINGTON\_CHIZUK
MUNO\_CEMETERY 1XXBuriai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/31/2010 BALTIMORE, MD 21. Signature of Funeral Service Licers 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Kenne Disense ₽nysician/ End-Stack disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last physician and the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 24 hours after death.
Funeral Director; After this certific leted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗂 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manper of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hor To the Fune completed fil 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MS Kyapahrem.D 12/29/10 D0057465

Registrar
DHMH 17 Rev 7/2009

State

5mi14

Av. 5-203, Baltimore, MD. 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

NS-ROLPAKE, M.D.

31. Date filed (Month, Day, Year)

JAN 0 3 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 20¥ñ 3:10 Рм Charlotte Marie Biemer Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Finksburg 2312 Highland View Drive Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min. Yrs Mary land Director 217-38-7072 1941 Usual Residence of Decedent show 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No Towson Md. Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21204 USA 1 Smeton Place Unit 1107 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. P. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: White Specify: "natural" Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Nurse other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ္ Towner <u>George</u> Getz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Joseph D. Biemer/ Husband Towson, Md. 21204 Smeton Pl. Unit 1107 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Timonium, Md. Dulanev Vallev Mem. 1-4-11 Donation 5 Other (Specify) 21. Signature o Funera Service Lice se e 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine fl any, leading to mimediate cause. Enter Underlying Cause (Disease or linjury that initiated events pue to for as a consequence on resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Month Day Year Pregnant at time of death by the a tached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 2 🗆 No Yes 2 1 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) 6 Nomerspecify's Home Hospital: 2 M No Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after dea. ral Director: Aftr 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 W300 nrued State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30 1:37 December 2010 Рм С. Stewart Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Gilchrist Baltimore 8. Date of Birth (Month, Day, Year) Sept 21. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Days Months Hours 1913 Mary Land 217-12-5251 Director 97 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director Parkville 1 ☐ Yes 2X No Baltimore Md.10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 27 Strabane Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Hardware Store Owner +1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Cavey Joseph Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane F. Gonter/ Daughter Strabane Ct. Parkville. Md.20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Dulaney Valley Mem. 1-4-11 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility on Funeral Home, 21. Signature of Functal Service Line nsee Towson. York Rd. Md. 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Dut to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consectionou offi trany, leading to infriedlate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 L Yes 2 L
9 Dunknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner as stated. nly c 007128 Name and address of person who completed cause of death (Item 23a) (Type. State Registrar

DHMH 17 Rev 7/2009

		Please			delible Ink. Ensure			Legible.	
	1	For State Registrar			artment of Health and tificate of Death		Reg. No.	2010	1 127
Physician Medica		1. Decedent's Name (First, Middle, Las	is Camp			2. Date of D Month Vecemt	er 3		3. Time of Death 8.28 A M
Examine		4a. Facility Name (if not institution, give SINAI HOSPITAL OF	BALTIMOLE		4b. City, Town, or Location of Dea	ath	4c.	County of Death	V/A
Funeral Director		5. Social Security Number  240 · 50 · 6860 1  Usual Residence of Decedent	X M 2 □ F 7. Age (II	n yrs. last birthday) 76 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi		irth Pay, Year	9. Birtl Cou	nplace (State or Foreign ntry) NC
6 ter death with the Maryland or items 23a or 28a-f show miner must be notified at	- 1	10a. State 10b. County		oc. City, Town or Loc Balta	more				10d. Inside City Limits 1 → Yes 2 □ No
with the s 23a or 3 ust be no	eral D	10e. Street and Number 2529 Keyworth	Avenue	)	10f. Zip Code 21215		10g. Cit	izen of What Col	
~ <u></u>	≥	11. Marital Status  1  Never Married 2 Married  3  Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates.		Vas Decedent of Hispanic Origin? (i Yes, specify Cuban, Mexican, Pue ☐ Yes 2 ★ No Specify:	Specify Yes or No rto Rican, etc.)		14. Race - Amer Black, White Specify:	
21215-0036 within 72 hours after glene. er than "natural", of the Medical Exam.	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)	ducation ide completed) College (1-4 or 5+)	(Give I	lent's Usual Occupation kind of work done during most of w O NOT use retired) VUCL DYIVEY	orking	16b. Ki	nd of Business I	ndustry MPany
Maryland 2 2 should be filed w 2 should be filed w th and Mental Hygi 27 is marked other traumatic event, t	as I-	17. Father's Name (First, Middle, Last) CONELLOUS Cai	MP		1	ame (First, Middle Y GVE			
Mar id 2 show salth and n 27 is m er traum		19a. Informant's Name/Relationship (Ty	(Wife)		g Address (Street and Number or I PKEYWOYTH AVE				
Baltimore, permit. Page 1 and Department of Hee Important: If item any injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	20b. Place of Dispo cemetery, cren	natory or other place)	Pate 1 2011		ocation - City or	
Balt permit. Depart Import any inj once.		21. Signature of Funeral Service Licens  Output  Output  C.				aughne. (Randa			21133
Fnysician/ Medical		23a. Part 1. Enter the disease, or come shock, or hearthailure. List only of mmediate Cause (Final disease or condition resulting in death)	ne cause on each line.	NCER WI	or the mode of dying, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
Examiner	Je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c	onsequence of):					
g	cai Examine	Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as a co	onsequence of):					
876C	Medic	IF FEMALE:	d						
Attending Physician: The law requires that the death certificate be eardeath.  sctor: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the buring the funeral director.	ysician/i	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at til 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
G. the page of the	2	Part II. Other significant conditions co	ontributing to death but	not resulting in the u	nderlying cause given in Part i.				the cause of death?
Record The law rectate has been page 2 sho	Completed		·			per	s an opsy formed? s 2 🔀 No	prior to death?	opsy findings available ompletion of cause of
fital sician: certific irector,	De De	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		26. Place of Death (C)				
of Vinda Bhysin ther this conneral direction		27. Manner of Death  1	28a. Date of injury (Month, Day, Y	2 ER/Outpatier 28b. Time of (ear) injury	28c. Injury at work?	Home 5 Res 28d. Describe			fy)
Division of Vital Records, as or Attending Physician: The law requires is after death.  I Director: After this certificate has been signed in by the funeral director, page 2 should be Completed.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined		- At home, farm, stre Specify)	M 1 Yes 2 No		(Street and		al Route Number,
Hospit Hospit Hour Funera	Medical	(Check 2 Medical Exami	ner: On the basis of exar	mination and/or invest	occured at the time, date and place igation, in my opinion, death occurre death occurred at the time, date and	ed at the time, date	and place	and due to the o	ause(s) and manner stat
To the I within 2 To the I comple		29b. Signature and title of certifier  Pajew grafts  A	1.B,B.S.		29c. License number			nber 30,0	
		30. Name and address of person who call RAJEEV GUPTA, MI	3,BS, SINAI	HOSPITAL	of BALTIMORE, 240	I W. BELVE	DERE T	WE, BALTI	MORE MD 212
State Registrar		31. Date filed (Month, Day Year) 0 3	2011 32. Registrar's	Signature A.	pares				
DHMH 17 Rev 7/2009	9								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 5:42 PM Velma Ermie Carter December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris Date or L. (Month, Day, Ye 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Virginia Days Hours 1 □ M 2 💥 F 212-26-6265 85 Director Sept. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2XX No Maryland Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral United States 21152 13921 Thornton Mill Rd. ed other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 X No Specify. Specify: white 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland မ Alma Jones John Gillispie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13921 Thornton Mill Rd. Sparks, MD J. Timothy Carter/son per it. Page 1 and 2 De artment of Health Important: If item 27 any injury or other tr once. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hunt Valley, Maryland Jan. 3,2011 Jessop Un Meth Ch Cem John O. Mitchell IV, Funeral Services of Dulaney Valley, 200 F. Padonia Rd. Timonium, MD 21093 21. Signature of Funeral Service Licensee Mitche 23a. Jart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P,O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ☐ Yes 2 ☐ No 2 X N within 24 hours a er death.

To the Funeral Director: After this certific completed filled in by the fur eral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) 2011 of person who completed cause of death (Item 23a) (Type, Print) . Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

BCL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mai	ryianu / i		cate of D			Reg. No		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					· · ·	2. Date of De Month	Da	y Year	3. Time of Death 7:45 A M
	Medic	al	Gilbert Clapperton  4a. Facility Name (if not institution, give st	treet and number)			City Town or	Location of Death	Decemb		9 2010 County of Death	7:43 AM
	Examin	er	Gilchrist Center	reet and namber)			owson	Location of Death		40	Baltimo	re
F	Funeral Director		000 30 3337		In yrs. last birt 71		Under 1 Year nths Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da Februar	th y, Year) y 25	9. Birthr Coun	place (State or Foreign try) laine
	ind show at	ō	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Locatio	n				1	0d. Inside City Limits
	Maryla 28a-f s otified	rect	Maryland Baltimore	ء	Luther	ville						1 ☐ Yes 2 💢 No
	s 23a or 2 s ust be no	<b>Funeral Director</b>	10e. Street and Number 8338 Tally-Ho Rd.				of. Zip Code 21093			Uni	tizen of What Cour ted Stat	
36	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	er in U.S. o		Decedent of His , specify Cubar Yes 2∑ No	ecify Yes or No- o Rican, etc.)		14. Race - Americ Black, White, Specify: whit	etc.	
<u>5</u>	2 hours "natura edical E	Completed	15. Decedent's Edu (Specify only highest grad	ıcation	16a	(Give kind	s Usual Occupa of work done d	ation uring most of wor	king	16b. K	Kind of Business Inc	dustry
1212	within 7 giene. er than the M		Elementary/Seconday (0-12)	College (1-4 or 5+) 5 <b>+</b>	) p		Tuse retired)			ps	ychology	
Maryland 21215-0036	ould be filed of Mental Hyg marked oth matic event	To Be	17. Father's Name (First, Middle, Last) Gilbert Clapperton					18. Mother's Nan Birdena			Surname)	
Mary	1 and 2 should be of Health and Ment if item 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Type Helene Clapperton/v								Town, State, Zip (	_
re, l	of Healt of Healt if item 2 r other		20a. Method of Disposition		20b. Place o	f Disposition	11y-Ho  n (Name of ry or other place		thervil		MD 2109 ocation - City or To	
Baltimore,	Page nent ant: It		1 N Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)			y Vall	ey Mem G	ard Jan.			onium, M	
Ra	permit. Departn Importa any inju		21. Signature of Funeral Service Licenses	lell T		John 200	o Mitc O Mitc E Pado	hell Ty, nia Rd.	Funeral Timon	Serv ium,	rices of D MD 210	ulaney Valla 93 P./
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one Immediate Cause (Final	cations that caused to cause on each line.	0			g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as a		of):						9.0
	Ladifillici	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence	of):						
	eth cer rificate be executed attending physician and for use as the burial-transit	Medical Examiner	cause. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last	Due to (or as a	consequence	of):			_			
09/	e be e) lysician le buria	lical		d								
92	certificat ending ph use as th	/Mec	IF FEMALE:	3c. If yes, outcome of	f pregnancy						20 L Data of dally	
Box	ne death ce the atteno	Physician/M	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1 Live Birth 2 4 Pregnant at t	Fetal deat	th 3 🗆 Ec 5 🗆 Oti	topic pregnanc her (specify)	у			23d. Date of deliv Month	ery Day Year
	v requires that the de been signed by the should be detached	d by Pr	Part II. Other significant conditions con	_	t not resulting	in the under	rlying cause giv	en in Part I.			use contribute to the	ne cause of death?
Division of Vital Records,	The law requires sate has been sign page 2 should be	Completed by								psy ormed?	prior to co death?	psy findings available mpletion of cause of
a R	rsician: The law is certificate has birector, page 2 s	BeC	25. Was case referred to medical examiner?				26. Pla	ace of Death (Che	1 ∐ Yes ck only one)	2 X N	lo 1 🗆 Yes	2 L No
ī V	Physici this ce al direc	은	1 ☐ Yes 2 No		nt 2 ER/O	utpatient 3		4 □ Nursing F			6 Other (Specify	Hospice
o uo	ending F eath. or: After he funer	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day,		injury	28c. Injury work M 1 □		28d. Describe	now inju	ry occurred	
DIVISI	To the Hospital or Attending Physician: To thin 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.		arm, street, f	factory, office		28f. Location ( City or To		nd Number or Rura e)	l Route Number,
	n 24 hour n 24 hour ne Funera	Medical	29a. Certifier 1 Certifying Physic (Office 2 Medical Examination only one) 3 Certifying Nurse	cian: To the best of mer: On the basis of exa e Practioner: To the basis	amination and/	or investigati	ion, in my opinio	n, death occurred	at the time, date	and place	e, and due to the ca	use(s) and manner stated.
	To th	-	29b. Signature and title of certifier	700			29c. License			29d. Da	ate signed (Month,	Day, Year)
			So. Name and address of person who co	empleted cause of dea	ath (Item 23a)	(Type, Print)	200			10	109110	
			Philip Shaheen	,6701 N	1.Che	rless	14.5	ite 41	05 B	4/10	Useau.	1021204
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s signature	1. Lo	and					

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sean Campbell	State of Maryland / Department of Health and Mental Hy 1-For State  Certificate of Death	/giene Reg. No	2010 4128
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)	Date of Death     Month Day	3. Time of Death
Modical Examine	Obert Comp BCC	December 30,	2010 1925 1118
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1143 St. Paul Street  Baltimore	4	c. County of Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM	M/DD/YYYY) 9. Birthplace (State or
Director	217-90-4376 1 MM 2 F 44 Yrs. Months Days Hours Min.	8-2-	1966 Country) Lave
any	Usual Residence of Decedent  10a. State A 10b. County 10c. City, Town or Location	<u> </u>	10d. Inside City Limits
<b>.</b>			1 Yes 2 No
the Maryland a or 28a-f sh tiffed at once	10e. Street and Number 10f. Zip Code	10g. Ci	itizen of What Country?
	1/23 SAINT Paul Apt I Rear 2/205		USA
or items 23	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp		14. Race - American Indian, Black, White, etc.
or its	1 Yes 2 No	rtiouri, oto.)	Specify: Black
ins after in miner	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w.	ork done 16b.	Kind of Business/Industry
72 hou and Example of each	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retir		HAUC
215-0036 be filed within 72 hours at natal Hygiene. rked other than "natural out, the Medical Examin Be Completed by	12 Student		,
15-C		(First, Middle, Maider	n Surname)
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than antic event, the Medical TO Be Comple	19a_Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or 1	ural Route Number, (	City or Town, State, Zip Code)
MD 42 sho the and the	Betty Harris (mother 12636 Ashland An	e. Balt	to. Md. 21205
ω _ ≖	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c.	Location - City or Town, State
Page	4 Donation/8 Other/Specify: M+ Zion Cometery 1/	7/11/	Balto. Md.
Baltimore, permit. Pages I as Department of Hee Important: If ite	21. Signature in the ral Se vice Usergee  22. Name and Address of Facility ( )	ef emeto	Backs. med.
Physician	23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	respiratory arrest, sh	Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final discusse a Left Ventricular Hypertrophy	Cardiomeg	Death
	or condition resulting in death)  Due to (or as a consequence of):		
Jer Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of). cause. Enter Underlying Cause		
ted Insit	C. C. Due to (or as a consequence of):		
scuted and transit	d.		
to, e be executed ysician and burial - transit	■ MENDED 23a,27 per me g912 2-4-11 vt		
8760 ificate ig phy is the b	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnan		3d. Date of delivery  Month Day Year
the death certificate the death certificate by the attending phyched for use as the Physician/M	past 12 months?  4 Pregnant at time of death 5 Other (Specify)		,
D. BC at the degrached for a Physical P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tobacco	o use contribute to the cause of death?
, P.O. res that the signed by be detacled by F.O.			No 3 Probably 4 ✔ Unknown
Records, The law requires ficate has been sig page 2 should be Completed		24a. Was an	24b. Were autopsy findings available
eco he law te has ge 2 s		autopsy performed?	
tal Recidins: The certificate ector, page	25. Was case referred to medical 26.Place of Death (Check of		
Physici or this c ral direc	1 163 2 100		dence 6 🗸 Other: Scene
Division of Vital Records, rail or Attending Physician: The law requirers after death.  In Director: After this certificate has been sited in by the funeral director, page 2 should be refification: To Be Completed	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 X Natural 5 Pending	28d. Describe how in	jury occurred
isior Attend er death. rector: by the	2 Accident Investigation 28e Place of Injury - At home farm street, factory office building, etc.	28f. Location (Street	and Number or Rural Route Number, City
Division o Septral or Attending hours after death. meral Director: Aft y filled in by the func Certification:	Suicide 6 Could not be determined (Specify)	or Town, State)	
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and		
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.  29b. Signature and title of certifier 29c. License number		
2	29b. Signature and title of certifier  O.C.M.E.		Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)		
	Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD	21223	
State	31. Date filed (Month, Day, Year) 32. Registrer's Signature		

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 41282 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 24, 2010 0640 hrs Medical Examiner Cole Bryant 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Maryland General Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Days Hours Min 219-88-8582 Director 45 02-15-65 Country) MD 1 M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 10a, State 10b. County 1XXYes 2 No or 28a-f show MD NA Baltimore Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1506 Argyle Avenue 21217 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, White, etc. African 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes If Yes, Give Year or Dates: 3 Widowed 1 Yes 2 No specify: specify: American 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Trucking Company 12th Grade NA17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 8 Ε. Willie Cole, Sr. Freddie 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 1219 Newfield Road Baltimore, MD William E. Cole, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12-30-10 Catonsville, MD Western Star Cem. 4 Donation 5 Other Specify 22 Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Sewice Licens 638 N. Gilmor Street Baltimore, MD 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Pârt I. Enter the unsease, of the failure. List only one cause on each fine.

Narcotic intoxication Between Onset and /Medical Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician and ed for use as the burial - trans cian/Medical AMENDED 23a,27,28a-f,per ME g911 1/4/11 TT X UNPENDED The law requires that the death certificate be Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23d. Date of delivery 23c. If yes, outcome of pregnancy Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? 5 Other (Specify) 1 Yes 2 No 9 Unknown Phys 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 Yes 2 No 3 Probably 4 V Unknown leted 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural unk 1 Yes 2 No 5 Pending I Director: ed in by the f within 24 hours after death.

To the Funeral Director: Fd 12/24/10 Fd 5:30 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Residence 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1506 Argyle Ave 3 6 X Could not be Suicide determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 25, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (Month, Day Year) 32. Registra s Signature State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

**OCME** 

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:20 PMM 2010 Charles William Campbell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 X M 2 □ F Months Days Hours Min 06/26/1940 Director 216-48-2356 Maryland Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at death with the Maryland Director 1 🗌 Yes 2 😾 No Harford MD Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2313 Chevenne Avenue 21085 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. ō þ 1 X Never Married 2 ☐ Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygreine. Important, If item 27 is marked other than Important, If item 27 is marked other than Me Elementary/Seconday (0-12) College (1-4 or 5+) Disabled N/ABe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Thelma Catherine Beyer Charles William Campbell, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Evelyn Hughes South Kelly Avenue - Bel Air, Maryland 21014 Baltimore, | 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/31/2010 Baltimore, Maryland Inc 21. Signature of Funeral Service Liçensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. - Kingsville, Maryland 11750 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or regire ory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ intracerebra disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to in modiate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of ig physician and as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be de Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy performed<sup>a</sup> death? 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical exampler?

1 4 Yes 2 No Be ( 26. Place of Death (Check only one) Hospital: Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Accident 5 Pending unwittnessed 28/10 2 No 1 Yes Un Known M Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 44 North Hickory Avenue Bulfir 21014 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) e of certifier 29d. Date signed (Month, Day, Year) Illannan, ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Drive Bel Air, MD 21014 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month e **Physician** 2010 December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 2–28–1979 5. Social Security Number Age (In yrs. last birthday, Days **Funeral** 31 220-96-8420 M **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland or 28a-f show notified at 10a State 10h. County 1 ☐ Yes 2 ☐XNo Director Owings Mills MD Baltimore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number r items 23a or 2 iner must be no death with USA 21117 4606 Waterfall Court, Apt. H Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? 12. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Examiner 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married X No Baltimore, Maryland 21215-0036 Specify ō 1 Tes Specify:African-American ģ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) al Hygiene. Elementary/Secondary (0-12) Self-Employed Hairstylist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Davena Peacock Robert Johnson ဂ္ဂ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4606 Waterfall Court, Apt. H, Owings Mills, MD 21117 Devin Chambers/ Husband Health : 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition □ Burial 2 □ Cremation 3 □ Removal from State
 □ Donation 5 □ Other (Specify) Department of important: if it any any injury or o ō 1-4-2011 King Memorial Park Woodlawn, MD 21. Si n re of Funeral Service Licenses 22. Name and Address of Facility Whie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hodgkin's **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) physician and as the burial-tr resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 2 No certificate 25. Was case referred to medical 26. Place of Death Check only one Be examiner? Hospital: 1 Inpatient Other: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To hours after death. 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 Nes 2 No 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 🗌 Homicide within 24 hours To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar venkato NarL 0 32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.O

600 North Wolfe St, Baltimore, MD, 21287

December 28

2010

RES-0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 23, 2010 2355 Nirmal Chopra М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery Olney 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 1 🗆 M 2 🔀 F Months Days Hours <sup>Country</sup> Pakistan ear 1935 215-02-1005 Augus E Director 75 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 406 Firestone Drive 20905 India "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates ☐ Yes 2 🛣 No Specify: Asian Indian Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o . Page 1 and 2 should be fill treent of Health and Mental tant: If item 27 is marked o Dev Datt Wahi Krishna Wat Wahi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deepa Chopra/Daughter in law 406 Firestone Drive, Silver Spring, Maryland 20905 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. December 26 cemetery crematory or other place West Arundel Crematory 1 ☐ Burial 2 🄀 Cremation 3 ☐ Removal from State 2010 4 Donation 5 Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 MO1386 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed<sup>a</sup> 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 Tes 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ziba Shirani, M.D., 18101 Prince Philip Drive, Olney, Maryland 20832

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) . .

2 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death December 28, 2010 Physician/ 5:50 A.M Geraldine Coy Beverly Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Ellicott City Shangri-La Nursing Home 8. Date of Birth (Month, Pay, Year) Dec. 16, 1928 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Days Hours New York Dec. 097-22-5965 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Funeral Director 1 Yes 2 X No Germantown Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20874 20518 Bridger Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. ral", or iten Examiner r Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😿 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced "natural" Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home Homemaker 12 other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental I 27 is marked or er traumatic eve ည Troy Martha Brown Leslie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20518 Bridger Way, Germantown, Maryland 20874 Department of Health Important: If item 27 any injury or other the once. Lisa Voss (niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 【 Cremation 3 ☐ Removal from State Glen Burnie, Maryland 30DEC.2010 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin KNOIIs Rd. Columbia, Maryland 21045 21. Signature of Suneral Se MUDSOY art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 YRS. Immediate Cause (Final Physician/ ALZHEIMER'S DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examiner Due to (or as a consequence of): g physician and is the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes 2 No Hospital: Other: 4 - Nursing Home 5 - Residence 6 A Other (SASIS) t. Living 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Director: After this in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural
Accident
Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DEC. 29, 2010 D56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Snowden River Parkway. # 301, Columbia, Maryland 21045

Registrar DHMH 17 Rev 7/2009

State

Harry Li,

31. Date filed (Month, Day, Yan)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ To, 20To Jack W. Castle December 9:00 PM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy Frederick 5 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Days 1 M 2 🗆 F Months Hours Min. July 23, 1926 Maryland Director 216-22-2097 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 12 from a man.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 207 S. Jefferson Street 21701 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces Yes 2 No Yes, Give Black, White, etc. þ 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🔽 No Specify Specify: white 3 Widowed 4 Divorced Completed 144-146 Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Carrie Estelle Mossberg Gilmer Tobias Castle Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21701 207 S. Jefferson Street Frederick, MD Louise Snyder/sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ronald S. Wade 21. Signature of State Anatomy Board 655 W. Baltimore Street Raltimore MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). that the death certificate be executed use as the bunial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Year Month Dav Pregnant at time of death 5 Other (specify) been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed; 1 Yes 2 No or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After 1 Natural 5 Pending Accident 24 hours after death. Funeral Director: A 1 Yes 2 🗌 No Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 3.25 PM Allen Carr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Roseda mose nklin 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Oct 5, Days 1 ₹ M 2 □ F 1957Virginia Director 220-66-0407 53 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√√ No Baltimore Dunda1k 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21222 24 Kinship Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 21215-0036 1 ☐ Yes 2X No Specify: white Specify: 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) marine terminal fork lift operator 11 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Brandt Hansel Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
24 Kinship Road Dundalk, MD 21222 Melody Schmidt/friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) in state 21. Signature 1 Roma 1 28 late Adato My Board 655 W. Baltimore Street MD Baltimore 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Priysician Pa Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a sonsequence of, signed by the attending physician and defeached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🔊 No 3 ☐ Probably 4 ☐ Unknown cate has been siç ; page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? After this certificate I 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Tyes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be within 24 hours after death

To the Funeral Director: / Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 12 VOO KE MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 31. Date filed (Month, Day, Year)

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 31,2<sup>°ear</sup>10 Physician/ Cornell DECEMBER Frank Duncan 10:33A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON Social Security Number 7. Age (In yrs. last birthday) Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 F Months Days Hours Min. December 14 1916 New York 94 Director 127-05-5801 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Lutherville Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 U.S.A. 3 Yearling Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) the Law Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Bettie Duncan ρ Grace permit. Page 1 and 2 should be I Department of Health and Menta Important; If item 27 is marked any Injury or other traumatic en once. William Burgess Cornell, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8340 Simpson Hill Drive Cedar Hill, Missouri 63016 19a. Informant's Name/Relationship (Type, Print) BettieHaug / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Hilltop Service Corp. 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 1/3/2011 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fun 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition PNEUMONIA Physician/ DAYS Medical resulting in death) Due to (or as a consequence of): **Examiner** YEARS BRONCHIECTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine YEARS Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi PARALYTIC BULBAR POLIOMYELITIS and attending physiciar Physician/Medical CHRONIC OBSTRUCTIVE PULMONARY DISEASE Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending after death. 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nyrse Practioner: T e best of my knowledge. death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of certifier 29d. Dafe signed (Month, Day, Year) 3 D 22645 no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w

State Registrar

7601 OSLER DRIVE. TOWSON. M.D.31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

MARYLAND

10-10023	
Mark Craig	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 41290 State of Maryland / Department of Health and Mental Hygiene

		Registrar		Cer	tificate of	Death			Reg. No	D.		
Physici Medical Exami		1. Decedent's Name (First, Midd Mark R. Craig	le,Last)					2. Date of D Month Decemi	Dav	2010 Yea		3. Time of Death 1517 hrs
		4a. Facility Name (if not institution 2205 Pelham Avenue						eath	[4	c. County o	f Death	
Funeral Director		5. Social Security Number 220-88-9755	6. Sex	7. Age (In yrs. la 50	ast birthday) Yrs.	If Under 1 Year Months Day		Hrs. 8. Date of Min. August	,		Constan	pplace (State or ntryMaryland
nd sbow any nce.	٥r	Usual Residence of Decedent  10a. State 10b. County  Maryland N	/A	10c. City,	Town or Location						- 1	10d. Inside City Limits 1 X Yes 2 No
ith the Maryland  23a or 28a-f sho notified at once	Director	10e. Street and Number 2205 Pelham Avenu	ue	<u> </u>		10f. Zip Code 2121	3			itizen of Wh	at Coun	ry?
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 13a or 28a-f sho the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 X Never Married 2 M 3 Widowed 4 Div 15. Decedent's Education (Spe	arried Armed F  1 Yes  orced If Yes, Give Ye or Dates:	2 X No	If Ye	Decedent of Hises, specify Cubar  Yes 2 X No	specify:	erto Rican, etc.)		14. Race White Specify: Kind of Bus	, etc. White	
136 hin 72 hour e. than "natt	Completed	Elementary/Secondary (0-12)		1-4 or 5+)	during mo	ector				Martin		•
MD 21215-0036 12 should be filed within 72 hou th and Mental Hygiene. 127 is marked other than "nat ummite event, the Medical Exa	Be Con	17. Father's Name (First, Middle, Samuel A. Craig					18.Mother's Na	eme (First, Middl Esther I			an	
Shoul shoul A 1 is a	욘	19a. Informant's Name/Relations Mary R. Craig/ Sis			417	Address (Stree Mundock Ro	oad Balt	timore Mar	ryland	d 2121	2	
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2		20a. Method of Disposition  1	pecify:	rom State C	cred Hear	t of Jesus	s 1	Date 12/30/10	200	Location - Dunda	-	own, State aryland
Physician		23a. Part I. Enter the disease, or	felle	caused the death.	1 530	ame and Address Nard J. Ri 5 Harford e mode of dving.	Road Ba	<u>altimore l</u>				Approximate Interval
Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. Head and			, .						Between Onset and Death
d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of								
760, icate be executed physician and the burial - transit	n/Medical E	UNPENDED	d AMENDED						-			
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed teath.  for: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unit	ne 1 Live	nant at time of dea	2 Feta	al death 3 [ er (Specify)	Ectopic pre	gnancy	2:	3d. Date of o	delivery Da	ay Year
P.O. E	d by Ph	Part II. Other significant condit	ions contributing t	o death but not re	esulting in the ur	nderlying cause g	jiven in Part I.				_	ne cause of death?
Division of Vital Records, tal or Attending Physician: The law require its after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed							1 ✓ Ye	topsy rform <u>ed</u> ?	pı de		opsy findings available impletion of cause of
F Vital Physician: r this certi	To Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital: 1		ER/Outpatient	3 DOA		rsing Home 5		lence 6		Scene
Sion of Attending Pl death. Extor: After by the funeral	Certification:	27. Manner of Death  1 Natural 5 Pend 2 ✓ Accident Invest	stigation	2010 (2010)	28b. Time of In	1 \	y at Work? ∕es 2 ✓ No	28d. Describ	stairs			
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Certific	4 Homicide deter	mined (Specify)	se of Injury - At ho Single Fam	ily Home			or Towr 2205 Pelha	n, State) m Aven	ue, Baltim	ore, Mo	
To the Ho within 24. To the Fu	Medical	(Check only one) 2 Medicai Exa	hysician: To the bearing in the basis and manner s	of examination ar		on, in my opinion	, death occurre		ite and p	lace, and du	e to the	cause(s)
	2	29b. Signature and title of certifie	Halli	ln		29c. Licens				cember 2		h, Day, Year) 10
0		30. Name and address of person Carol Allan, MD Ass	who completed cau sistant Medical			treet, Baltimo	ore, MD 21	201				
St	ate	31. Date filed (Month, Day, Year)	32. R	egistrar's Signatui	re							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12-23-2078 0528 AM Whitelock Dougherty Virginia 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) North East 37 South Leslie Road 8. Date of Birth
(Month Pay Year) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours Marykand 1 □ M 2 🕱 F 86 219-12-8339 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No North East Maryland Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States of America 21901 37 South Leslie Road Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Specify: White 1 ☐Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Family Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Beulah Flowers 17. Father's Name (First, Middle, Last) Walter Viar 19a. Informant's Name/Relationship (Type, Print) Thomas Caine, St. (Son) 19h Mailing Address (Street and Number or Flural Floute Number City of Lown, State, Air Godd) and 774 St. James Terriace, Havne ale Grace, Mary James 1972 21078 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Fallston Methodist Cem. 12/29/2010 Fallston, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, T.A. 21078 21. Signature of Superal Service L 123 S Washington St, Havre de Grace, Maryland 8 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myound mtecence Due to (or as a consequence of): newcomi Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Amurel Due to (or as a consequence of) Hypothendism 23c, if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 27, Manner of Death 28c. Injury at Work? 17 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

/Medical Examiner Box 68760, P.0. Division of Vital Records,

The law requires that the death certificate be executed and burial-trar the attending physician the nse for 1

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Eventinal to suffice at any injury or other traumatic event, Ite Medical Eventinal to so that

**Physician** 

Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

29a. Certifier

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica ours after death.

eral Director: After this certific filled in by the funeral director, I To the within 2

> State Registrar

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

an coo Har

1004823

12/23/10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

west man Sty EllCton, Ad 21921 MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 00 Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Seasons Hospice 8. Date of Birth (Month, Day, 3-4-192 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours Min. 1 □ M 2X□ F Yrs Director 246**-3**0**-979**0 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 □ No M Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21206 USA 5522 Silverbell Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: African-American 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dietary Aide Dietician Church Home and Hospital 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin McMiller Gwendolyn Faton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5522 Silverbell Road, Balto. Md 21206 Diane Walker/ Daughter 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1-4-2011 Woodlawn, MD Donation 5 D Other (Specify) King Memorial Park 22. Name and Address of Facility Wile FuneralHome P.A. of Balto. Co. 21. Signatu of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine any, leading to immediate cause. Enter Underlying Due to for as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury use as the burial-tranthat initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown cate has been signed by the a page 2 should be detached 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy perform 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 2 **7** No ျှ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural Accident Duicide work? 5 Pending 1 ☐ Yes 2 ☐ No Investigation 24 hours after death Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year) filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

**Funeral** Director

death with the Maryland

r 28a-f show notified at 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it filed within 72 hours after 1 and 2 should be fill Health and Mental H tem 27 Is marked oth Department of Health Important: If item 27 any Injury or other tr Pages 1

**Physician** /Medical Examiner

Baltimore,

P.O. Box 68760.

Division or Vital Records,

that the death certificate be executed sician and burial-tran physician a for þ signed to page 2 s certificate director this funeral After To the Hospital or Attending within 24 hours after death. Director: in 24 hours.

the Funeral Director

Note filled in by

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Mary - Darmino -Mary Darminio 8:50A M December 14 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing Home Columbia Howard If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 🕅 F July 16, 1912 Ohio 105-01-9073 98 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 ☐ Yes 2X No Director Maryland | Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8100 Oakberry Court 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2**XX**No Specify: White ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Loan Officier Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Gough Mary Kruse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Hart (Daughter) 504 Brentwood Ave. Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sr. Mary's Cemetery 12-20-2010 Dewitt, New York 21. Signature of Funeral Service Licenses Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part1. Enter the dia 11e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE DAYS Due to (or as a consequence of): FIBRILLATION MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner SEVERE CORONARY Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> PERIPHERAZ VASCULAR 1 Yes 2 No 3 Probabiy 4 Unknown Be Completed HYPERTENSION PERIPHERAL ARTERIAL DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an THROMBOSIS DEEP VENOUS 1□ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0069962 Katima Ah 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6334 CEDAR LANE, MD, 21044 NAQVII 31. Date filed (Month, Day State Registrar

To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical DAYHOFF December 2010 4:28 WAYNE TRA 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick Social Security Number Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday, If Under 1 8 Date of Birth **Funeral** (Month, Day, Yea 1 X M 2 🗆 F Months Days Hours Min. Director 218-40-2793 68 Mar. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 XNo Maryland Frederick Walkersville 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 10433 Daysville Rd 21793 U.S.A or items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married ≥ Maryland 21215-0036 hours after 1 ☐ Yes 2 🛣 No Specify: If Yes Give "natural", 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than " any injury or other traumatic event the March Elementary/Seconday (0-12) College (1-4 or 5+) 8 construction carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည James Henry Dayhoff Nettie Ella Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine M. Dayhoff/ wife 10433 DAysville Rd. Walkersville, MD 21793 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Mount Hope Cemetery 12/30/2010 | Woodsboro, MD 21. Sign turn of Funeral Service Lice 22. Name and Address of Facility Hartzler Funeral Home Woodsboro, MD 21798 Main St. 404 S. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final End Stage Onset and Death Pnysician. Disease disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month detached 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? by Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed<sup>a</sup> death? 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 MDD 62180 30. Name and address of pe ompleted cause of death (Item 23a) (Type, Print) 7th St\_ Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN U 3 2011 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kathryn Gracie Drabic 3:30 P. M December 2010 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Genesis Eldercare Nursing Home Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 1 M 2 X F (Month, Day, Year) 02/07/1935 206 30 8877 Indiana 75 Director Usual Residence of Decedent 10h County 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified N/A Baltimore 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3709 - 5th Street 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0. 2 X No ð 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 XWidowed 4 Divorced White Year or Dates ed other than "nature event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Restaurant Waitress 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Vinson Goldie Mae Cornelius Page 1 and 2 should be ment of Health and Menta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21225 27 William Drabic Sr. / 3709 - 5th Street rartment of Health rortant: If item 27 y injury or other t Baltimore, 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 12/28/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) per rit. I Der artn Imr orts any inju 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 If 1. Enter the disea s, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Onset and Death Immediate Cause (Final Physician/ disease or condition newmonin Medical resulting in death) Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown for Pregnant at time of death should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No has certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner?
1 Yes 10 Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: Natural 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a, Certifier 🗠 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fil 3 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature a 21061 dress of person who completed cause of death (Item 23a) (Type, Print) Burnie 7845 WD

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Juxce Evans Deamber Medical Facility Name (if not institution, give street and number) Examiner tou anda imore 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖼 Month, Day, Year) 2 Country) Director ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No imore 10e. Street and Numb 10g. Citizen of What Country? Funeral 2120 death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married "natural", or Completed by 1 ☐ Yes If Yes, Give 2 No within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify 3 ₩idowed 4 ☐ Divorced lac Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during life\_DQ NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College #1-4 or 5+) Be 17. Father's Name (First, Middle, Last 18. Morther's Name (First, Middle, Maiden Surname, Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) an Baltimore, 20a. Method of Disposition Place of Disposition (Name of temetery, crematory or other) 20c. Location - City or Town, State Burial 2 Cremation any injury or 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 87281 Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myelegenrus Leulenia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence on. sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 as the t IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No detached 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be The law requires Records, Completed 1 Yes 2 🗖 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 🗌 No 1 Yes **Division of Vital** Hospital or Attending Physician: director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? ပ 2 🗆 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' n 24 hours after death. le Funeral Director: Aft pleted filled in by the fur 1 Yes 2 No Investigation 6 Could not be ☐ Accident 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier

MIMMFMM D 29d. Date signed (Month, Day, Year) DOOS 7 465 12/29/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Rignon Kee, M.D. 2835 Sm IM N-

Registrar DHMH 17 Rev 7/2009

State

Jack

32. Registrar's Signature

N.S. Rigapakse, MiD.

JANO

31. Date filed (Month, Day, Year)

5-203,

Baltimure.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 4:00AM CATHERINE ELIZABETH EURICE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 6302 Ebenezer Rd. Baltimore County 8. Date of Birth (Month, Day, May 10, 5. Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🕱 F Hours 215-22-9292 83 Director Maryland Usual Residence of Decedent r Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Baltimore County Maryland Baltimore 1 🗆 Yes 2 💢 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral 21220 USA 6302 Ebenezer Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2XXMarried Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping-Own Home N/A Housewife 10th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Mohr Charles Stumpf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6302 Ebenezer Rd. Baltimore, Md. 21220 19a. Informant's Name/Relationship (Type, Print) Joseph V. Eurice,Sr. (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Date tXX Burial 2 ☐ Cremation 3 ☐ Removal from State Important; I any injury or Gardens of Faith 12-29-2010 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Lassahn Funeral Home das 7401 Belair Rd. Baltimore Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a con equence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 Yo for Month Day Year Pregnant at time of death the detached g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available anset diabetes mellitus 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? has 1 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28d. Describe how injury occurred (Month, Day, Year) Watural 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🛮 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours after deat To the Funeral Director; To the Hospital

State

only one)

31. Date filed (Month, Day

29b. Signature and title of certifier

Registrar

Dietroh MD

30. Name anth-ordress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DOOSTAST

LIKE White March 4924 Campbell Blud Ste 200 Baltomb

29d. Date signed (Month, Day, Year)

29/10

21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 20Tb Physician/ 6:23 PM Powell Wesley Esham Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Columbia Harmony Hall Assisted Living 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7, Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. 1 XM 2 □ F Months Days Hours *™20*21928 82 215-24-5082 **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State **Funeral Director** 1 ☐ Yes 2xxNo Columbia Howard 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 21044 6336 Cedar Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Trucking Terminal Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Audrey Nock 0 Powell V. Esham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17716 Quail Covey Court Woodbine, MD 21197 Kathleen E. Erskine (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12-17-2010 | Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signard e of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. Columbia, MD 21045 5555 Twin Knolls Road aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications the shock, of leart failure. List only one cause on n each line Immediate Cause (Final disease or dition Cancer Pnysician/ Medical resulting in death) Due to (or as a conseque of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami and I-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 use as ed by the attending getached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant Day Pregnant at time of death Month Year in the past 12 months? 5 Other (specify) 🗌 Yes 2 🔲 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 After this certificate has 26. Place of Death (Check only one) 155,5TED • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my online, date has been and been and place, and due to the cause(s) and manner stated.

Certifying Tripstoan: To the basis of examination and/or investigation, in my online, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Tripstoan: To the basis of examination and/or investigation, in my online, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) State J 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce MD 137750 cause of death (Item 23a) (Type, Print) 30. Name and address of person who complet 63/38 Columbia, Maryland 21044 Brian Sharkey Cedar Lane Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month .30 an Robert Wallace Evans December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Dove House Westminster Carroll 8. Date of Birth
(Month, Day, Year)
June 24. . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Days 1 🕱 M 2 🗆 F Hours Director 928 Pennsylvania 209-18-8203 Usual Residence of Decedent fshow 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland **Funeral Director** traumatic event, the Medical Examiner must be notified at Carroll MD or 28a-1 Westminster 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a AT 131 505 High Acre Drive 21157 United States of Americ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 5 à 1 Never Married 2 Married 1 X Yes 2 If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental ည Page 1 and 2 should be 1 Llewellyn Evans Louise Stanton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey W. Evans (Spouse) 505 High Acre Drive, Apt 131, Westminster, MD 21157 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o once. 12-29-2010 <u>Atlan</u>tic Crematory Glen Burnie, MD. 21061 21. Signature of Funeral Service Licer 22. Name and Address of FacilityWitzke Funeral Homes, Inc. (1100804 5555 Twin Knolls Road, Columbia, MD 21045 23a art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between O set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Sofor Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 N Yes 2 1 Tyes 25. Was case referred to cical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Unfural iniury 5 Pending Accident Director: A Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Dav. Year) cause of death (Item 23a) (Type, Print) 31. Date filed (Mo State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Catherine Ida Ehlers 5:35a 31 2010 December /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Summerville Assisted Living Westminster Carroll 8. Date of Birth (Month, Day, Year)
110 9 1927 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 X F 83 Yrs 214-26-0726 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 🔏 No MD Carroll Westminster Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21157 45 Washington Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white 2 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If item 27 is marked other 1 any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Briscoe Alice Kirkman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Bramucci (daughter) 3517 Beechwood Rd., Garnet Valley, PA 19060 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Lake View Memorial Sykesville, MD 1-5-11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Paign Haight of P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any Lamb cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 I Inknown 9 Unknown by Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1∐ Yes Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Assisted Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of e Hospital or Attending P 24 hours after death. e Funeral Director: After t After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident сотріете filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,

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State

Registrar

JAN O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 2° 29 2010 Physician/ 12:45 AM 4a. Eacility Name (if not institution, give street and number) Ewachiw Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Baltimore Medical enter rowson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye) Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Days Hours Mary land Director 267-64-9893 70 1940 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🏖 No Lutherville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1512 Charmuth Road 21093 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy important: If item 27 is marked oth any injury or other them. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 9 Dolores Amrhein Fred L. Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1512 Charmuth Road, Lutherville, MD 21093 Eugene Ewachiw/ husband 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Dulanev Vallev Mem. 1/3/2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Homé, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardio HYrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \_\_ Live Birth 2 \_\_ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

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9 Unknown Dav Pregnant at time of death g Unknown signed by the Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acidosis 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death? autopsy page Periphera 25. Was case regred to medical After this certificate 2 X No 1 Yes Yes Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 X No 1 Ninpatient 2 ER/Outpatient 3 DOA 은 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State within 24 hours a

To the Funeral C

completed filled Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Pay, Year) death (Item 23a) (Type, moth 31. Date filed (Month, Day State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 0 4 302 amend #State of Maryland 7 Department of Health and Mental Hygiene

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		4a. Facility Name (if not institution, give	street and number)			r Location of Deat	th	4c. County of	Death
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Funeral	- 1	Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Ye  Months Da			· ·	Birthplace (State or Foreign
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - mansi	B	examiner?	ospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	Other Nurs	sing Home 5	Residence 6	Other: Scene
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To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examine	n the basis of examination a	nd/or investig	ation, in my opinio	on, death occurred	d at the time, date	and place, and du	e to the cause(s)
To vit	ě	29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number		29d. Date signe	(Month, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 1110 2010 Decembe /Medical 4c. County of Death 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City**  Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days MM 2 F 5/12/1944 Director Maryland 66 215-40-9034 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show at 1X Yes 2 □ No Director must be notified 28a-f Baltimore Maryland 10g. Citizen of What Country? 10f. Zin-Code 10e. Street and Number 6 23a death Funeral 409 52nd Street . A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married 1 ☐ Yes 2 [ If Yes, Give Year or Dates 2 XNo 0 21215-0036 1 Yes 2 No Specify. Specify: þ 3 Widowed 4 Divorced White naturai" Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Hardware Store <u>Sales Manager</u> of Health and Mental Hygir filem 27 is marked other r other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Ada Mae Zable 2 William Henry Freyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathryn Elizabeth Freyer (Wife) 409 52nd Street Baltimore, Maryland 21224 Baltimore. Date 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) ٠ <del>= ١</del> 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important; if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2011 Middle River, Maryland Holly Hill Mem. Gard 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** ieukemia Sequentially list conditions, it is a leading to mine that cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical nding use a 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy atten I for u Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has certificate has director, page 2 2 🗌 No 1 TYes 2 No. 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannes of Death Certification: After 1 Natural 5 Pending investigation Injury 1 🗌 Yes or safter dec. rai Director: At raby th 2 🗌 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatore and Vecember 31 2010 (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death 600 North Wolfe St, Baltimore, MD, 21287 0

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State

Registrar

31. Date filed (Month

Barker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 855AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Secour . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral Year 1960 Days Hours Min 1 ▼ M 2 □ F 219-84-8154 **Director** Maryland Sept Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 1√2 Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21223 1217 W. Fayette Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1 X Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) fast food industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Estelle Jordan ၉ Thomas Edward Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2413 Arunah Avenue Baltimore, MD 21216 Cassaundra Averette/sister 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) in State cemetery, crematory or other place) 4 ☐ Donation 5 X Other (Specify) Signature of Euperal Service Processes ROHATO S Wade প্রথম প্রাথম প্রায়ের প্রথম বিষয় প্রথম বিষয় প্রথম প্রথম বিষয় প্রথম প্রথম বিষয় বিষয় প্রথম বিষয় ব 21201 BALtimore, MDEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, beart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 \ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page 1 Tes Yes 2 A 25. Was case referred to medical examiner?

1 ✓ Yes 2 ☐ No funeral director, Be 26. Place of Death (Check only one) Hospital ၉ 1 Inpatient 2 FR/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No e Hospital or Attending Pl 24 hours after death. e Funeral Director, After th Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu ss of person who completed oduse of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. In d #5 PER FH G911 1/11/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 2010 **Physician** FILLINGER 12 03.00A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BURNIE GLEN BURNIE ANNE ARUNDEL HEALTH AND KEHAB 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months Days 1 № M 2 🗆 F 220 05 08/19/1921 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modeal Examiner must be neitlified in once. N/A1X Yes 2 □ No Baltimore Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 4106 - 5th Street 21225 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Affiled Folces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White 2 3 ▼ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Proctor Gamble 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leon Foster Fillinger (not available) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9682 North Shore Drive Seaford, Delaware 19973 Susan Bowe / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/29/2010 | Baltimore, Maryland Holy Cross Cemeterv 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lie only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FIBRILLATION TRIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ENSION Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner FAILURE HEART The law requires that the death certificate be executed LONGESTIVE burial-transi and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the at d be detached for 1 ☐Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> LIPIDEMIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed To the Hospital or Attending Physician: The within 24 hours all er death.

To the Funeral Director After this certificate or completely filled in by the funeral director, page. 1 ☐ Yes 2 🖾 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

of Vital Records,

Division

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 3 20

3Q. Name and address of person who completed cause of death (Item 23a) (Type, Print)



10-10047 Vonita Gibbs

## Pleas

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State of Maryland / Department of Health and Mental Hygiene		110	

		Registrar		Септи	cate of	Deam				g. No.	
Physici Medical Exami									3. Time of Death 1103 hrs		
		4a. Facility Name (if not instituti	4b. City, Town, o	or Location of		<del>Jedember</del>	4c. County of	Death			
- 64		1709 Guilford Avenue				Baltimore				NIA	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. last bi	irthday)	If Under 1 Ye Months Da		24Hrs. 8 Min.			9. Birthplace (State or Foreign
Director		319-76-8872	1 M 2 F	50	Yrs		/		10-06	-1960	Country)
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Locati	on					10d. Inside City Limits
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daryla 28a-f	Director	10e. Street and Number	0 . 1	216	2	10f. Zip Code			10	g. Citizen of What	Country?
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Baltimore, permit. Pages 1 a Department of He Important: If its		24. Signature of Funeral Service	Licensee	/	22. N	ame and Addres	s of Facility	34	05 W	frank	unst.
Physician	- 11	23a. Part I Enter the disease, or	complications that ca	aused the death. Do n	ot enter th	e mode of dving	n. Was	llac	l F.J	t shock or heart	Approximate Interval
/Medical		failure. List only one cause	on each line.			o mode of dying	, saar as care	1100 01 100	phatory arres	it, shook, of fleart	8etween Onset and Death
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P.O. Es that the gned by the e detachec		Part II. Other significant condit	ions contributing to	death but not resulting	g in the ur	iderlying cause (	given in Part I		23e. Did toba	acco use contribut	e to the cause of death?
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	ertificati	2 🗹 Accident Inves	tigation Dec 26, 2	of Injury - At home, fa	3 hrs arm, street				Location (Str	eet and Number o	r Rural Route Number, City
Division At ours after dours after diffeed in by	erti		not be	Townhouse / R			idence	1609	or Town, Stat 9 Guilford A	te) venue, Apt. B, E	Baltimore, Md
Divisic To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th	S			of my knowledge, de							
To the Hos within 24 h To the Fur	Medical		and manner st	f examination and/or i	nvestigatio			red at the			
	~	29b. Signature and title of certifie	1,50/	1/100	1	29c. Licens O.C.I				29d. Date signed December 29	(Month, Day, Year)
	4	30. Name and address of person	who completed as a	of death (Itom 22c)			****				, 2010
		Victor Weedn MD JD		lical Examiner	900 W.	Baltimore S	treet, Balti	imore, l	MD 21223		
	ate	31. Date filed (Month, Day, Year)	32. Re	istrar's Ignature	,					- :	
Regist	rar	JAN U J ZUTT /	eneway po	gara							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 22, **Physician** December 2010 L. Gick 10:22 P <sup>M</sup> Frances /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard 6708 Handley Drive Elkridge 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05–24–1922 Birthplace (State or Foreign Country) **Funeral** ountry) st Virginia Months Days Hours Min. 88 West Director <u>236-28-5229</u> Usual Residence of Deceden death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2X No MD Howard Elkridge 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6708 Handley Drive 21075 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. filed within 72 hours after 1 ☐ Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XXNo ģ Specify. 3 ₩ Widowed 4 □ Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 0i1<u>Secretary</u> permit. Pages 1 and 2 should be filed: Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ <u>Luther Frazier</u> <u>Rena Morgan</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Deborah L. Sablowski- daughter</u> 6708 Handley Dr., Elkridge, MD 21075 Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Park | 12-29-2010 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc, 7250 Wash Blvd, Elkridge, MD 21075 04 23a. Part 1. Unter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Debility 1 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Rheumatoid Arthritis Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Dementia Months and burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical Hypertension Years the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Day Ye ar 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Type II Diabetes Mellitus 1 ☐ Yes 2 🗵 No 3 ☐ Probably 4 ☐ Unknown Completed Old Cerebral Infarction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2**/ N**0 2**X**XN0 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home \*\* Residence 6 Other (Specify) 1 ☐ Yes 2 📆 Xlo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a cal 29a. Certifier 1 XX certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) , mo D22832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Soon Ja Kim, M.D., 31. Date filed (Month, Day, Year)

JAN 03 20

ORIGINAL

32. Registrar's Signature

5808 Main Street, Elkridge, Maryland 21075

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8 Per FH G911 1/03/2011 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month e C Medical a. Facility Name (if not institution, give street and number) Examiner Jown, or Location of Death 1timore 0W501 If Under 1 Year If Under 24 Hrs. 6. Sex 8 Marochth 26, 1947 Birthplace (Str
Country) **Funeral** Age (In yrs. last birthday) 1 □ M 2 🗹 Months Days Hours Director ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "....any injury or other than "..... 10c. City, Town or Location 10d. Inside City Limits Director 1 ✓ Yes 2 ☐ No 10g. Citizen of What Country? Funeral 043 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No 1 ☐ Yes 2 ☑ No Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1 A or 5+) Be 17. Father's Name (First, Middle, Last) မ 55e XON ones 19a Informant's Name/Relationship (Type, Print) 2/043 tayes 1 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of City or Town, State cemetery, crematory or other place 4 Donation 5 Other (Specify) Jacksonville 21. Signature of Funeral Service Licensee Baltimore National 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pa disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Pregnant at time of death
Unknown Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy 2 NO 1 🗌 Yes 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 🗱 e of certifie 29d. Date signed: (Month. Day, Year) MD 25 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATHI N CH ARLIFS KUMAR 701 31. Date filed (Month 3 2 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:29 PM ANTHON 28. Medical 4a. Facility Name (if not institution, give street and number Examiner County of Death timore **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 ▼M 2 □ F Month Day, Country) Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho by Funeral Director City. Town or Location 10d. Inside City Limits STOWN 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 100 Yes Specify: Blac If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) river Be 17. Father's Name (First, Middle Mother's Name (First, Miodle, Maiden Surname ပ္ Inform t's Name/Relationship / ype 19b. Mailing Address (Street and Number or Rural Route No of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signat e of Funeral Service Licens Greene Funeral Services STOWN. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or regist failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician/ Onset and Death ANCKURTIC Medical Examiner MOUTHS Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or imjury that initiated as or injury Examine Due to or as a consequence of attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Unknown Dav signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performe Yes 2 No 2X No 1 Yes Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No ၉ Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 2 🗆 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) atitle of certifier 29d. Date signed (Month, Day, Year) WAN 30. Name and address of person who comp eted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:52 Juanita Higdon Hughes 2ďľo Ам December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours January 19, 1926 128-14-6704 North Carolina **Director** 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director Maryland Baltimore Timonium 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Dulaney Valley Rd. 21093 United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XX No Specify: Specify: white 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) registered nurse nursing of Health and Mental Hygin of Health and Mental Hygin fitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Harry Higdon Maude Sapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Hughes/son 2327 Garrett Rd. White Hall, MD 21161 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem GardDec. 30,2010 Timonium, Maryland John O. Mitchell IV, Funeral Services of Dulaney Vallay, 200 E. Padonia Rd. Timonium, MD 21093 P.A. 21. Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on an all line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ rea disease or condition Medical resulting in death) Due to or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Year Pregnant at time of death Month Day signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 🖎 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) JUANITA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 24 hours after deatl Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year, 0)05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 ERNESTINE WRIGHT, M.D.Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

DECEMBER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Pear December 29, 2010 **Physician** 8:20 PM HOWARD LEONHARDT HALSTEAD /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BLAKEHURST RETIREMENT COMMUNITY Baltimore County Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1√2 M 2□ F 213-07-6980 99 11, Director 0ct 1911 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State Show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23e or 28e-4 show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Baltimore County Towson Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 1055 West Joppa Road USA by Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Steel Company Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Thomas Halstead Bertha May Leonhardt P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other treum 1055 West Joppa Road, Towson, Maryland 21204 Rose Ellen Halstead (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/ 30/10 Catonsville, Marylan Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatural Service Lansee MITCHELL-WIEDEFELD FUNERAL HOME, INC. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner been signed by the attending physician and should be detached for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a sunsequence of): resulting in death) Last Division of Vital Records, P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed page 2 has 2 No 1 ☐ Yes 2 ☐ No 1 Yes certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home ို 1√2 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral di 28d. Describe how injury occurred numbers & leg 28b. Time of Injury 27. Manner of Death Certification: Use Partners & hip from
They want to JBM Route Number,
City or Town, State) 1055 St. Top DA Rd or Attending 1 Natural 5 ☐ Pending 12/20/2010 UNKNOWN 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in the Apartment 4 Homicide rowson MD ZIZOX 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KO 48402 Alwin M. Kern, CRNP Productioner

1055 W. Joppa Road, Towson, Maryland 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP,

32. Regis rar's Signature

Kern,

Susan M.

31. Date filed (Month, Day,

State Registrar

**DHMH 16 Rev 6/95** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 12:2/DM INEZ HOUSE , einber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth If Under 24 Hrs. Date of bill... (Month, Day, 1 9. Birthplace (State or Foreign Funeral 1 □ M 2XXF Months Days Hours Min Director VIRGINIA 89 219-16-7836 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified 1 X Yes 2 No BALTIMORE MARYLAND N/A10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be by Funeral 23a 823 REVERDY ROAD U.S.A er than "natural", or items the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 X No 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes XIX No Specify: Specify: BLACK 3XXWidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALES REP. 12th grade BAKERY and Mental Hygic is marked other permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ROGER MASON HATTIE POLLOCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne C. Miller/Daughter 4117 Holbrook Rd., Randallstown, Md., 21133 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 Doplation 5 Other (Specify) WOODLAWN CEMETERY 12-31-2010 WOODLAWN, MARYLAND Signature of Fune of Fire Strvice Lice 22 Name and Address of Facility POLITAN CHAPEL PC 1639 Broadway Baltimore. N. 23a. Part 1. Enter the disease shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine signed by the attending physician and a be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performe 1 
Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural Accident 5 Pending 1 Yes 2 🗌 No Investigation 24 hours after deatle Funeral Director: Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or inventioning in a stated. Medical 29a. Certifier сопретер 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0000 MU egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Tara J. Brunson-Hawkins

		- For State legistrar			ertificate (					Reg. No.			
Physician	7	1. Decedent's Name (First, Middle, Last) Tara J. Brunsen-Hawk					ns	2. Date of De Month	Day	Day Year			
Medical Examine		- faure	t Hav	ALA10 .	- Dien	207			Decemb				0000 1113
	ľ	4a. Facility Name (if not institution, 22 Cedar Heights Court	_	umber)			city, Town, or Lo wynn Oak	ocation of Death			. County of Saltimore		nty
Funeral		5. Social Security Number 6	S. Sex	7. Age (In yrs	s. last birthday)	If	Under 1 Year	If Under 24Hrs	8. Date of E	Birth (MM/I	DD/YYYY)	9. Birth	place (State or
Director		215-80-3443	1 M 2 F		49	rs.	nonths Days	Hours Min.	Aug.	11,10	761	Foreigr Cou	ntry) Mary land
		Usual Residence of Decedent		Lio. O	-								10d. Inside City Limits
d how any		10a. State 10b. County	UIA	10c. C	ity, Town or Loc	ation	Ba	Himore					1 Yes 2 No
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  In a marked other than "matural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number 325 N. Gra	ntley S	54.		10	f. Zip Code	1229		10g. Citiz	zen of Wha	at Count	try?
death with the or items 23a must be notificated in the contraction or items 23a must be notificated in the contraction or items 23a must be notificated in the contraction of the contra		11. Marital Status	Asses of C	cedent Ever in				anic Origin? ( Sp Mexican, Puerto		No-	14. Race - White,		an Indian, Black,
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ins aff	<u>-</u>	15. Decedent's Education (Specif	<u>l or Dates:</u> fy only highest gra	de completed)				n (Give kind of v		16b. K	Kind of Bus	iness/In	idustry
36 nin 72 hou s. than "na dical Ex	pajaidilloo	Elementary/Secondary (0-12)	College (	1-4 or 5+)	, , , , , , , , , , , , , , , , , , ,			OO NOT use reti		CI	ity of	2 Be	Hinore
21215-0036 Juld be filed within 72 Mental Hygiene marked other than ic event, the Medical		17. Father's Name (First, Middle, L				V	18	Anna C					_
Baltimore, MD 21215-005 Permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene Important: If item 71 is marked other ti injury or other traumatic event, the Med		19a. Informant's Name/Relationshi	p (Type, Print )	ēs-	19b. <b>M</b> ail	_	dress (Street a	and Number or F	Rural Route N	umber, Ci	ity or Town	, State,	Zip Code) 21117
ore, MD st 1 and 2 sho of Health and If item 27 is her traumati	ŀ	20a. Method of Disposition	3131		b. Place of Disp	osition	(Name of ceme		Date	1/			Fown, State
MOFC Pages 1 ent of I		1 Burial 2 Cremation 4 Donation 5 Other Spe	3 Removal fr	rom State	Jew Ca	the f	dral C	em. 12	50/10	Bo	attim	ore,	Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	T	21. Signature of Funeral Service L		10 1	22	. Name	and Address o	of Facility Par	Ker F	iner	4 He	me	P.A. 21229
Physician		23a. Part I. Enter the disease, or co	omplications that of	caused the dea	ath. Do not ente	<u>ර / උ</u> r the m	node of dying, su	uch as cardiac o	r respiratory a	rrest, sho	ock, or hea	rt/	Approximate Interval
/Medical	1	failure. List only one cause o											Between Onset and Death
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ted nisit		cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a										v
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be execician		X UNPENDED	<b>X</b> AMENDED	1,23a,	2/ per	me	g912 2-	-2-11 vt					
8760, ifficate be ng physic is the bur	E 2	IF FEMALE: 3b. Was decedent pregnant in the		outcome of pr	-			Fatania progra		230	d. Date of o	-	ay Year
K 68 n certif ending use as		past 12 months?	4 Pregr	oirth nant at time of	- da - 4h		(Specify)	Ectopic pregna	ilicy		WOTH		ay real
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Sall certific	9	25. Was case referred to medical examiner?	Hospital:	-				of Death (Check		7			
Physic Physic r this all dirr	<u> </u>	1 ✓ Yes 2 No	, ,	Inpatient 2	ER/Outpatie				g Home 5		ence 6		Scene
oding l		27. Manner of Death  1 X Natural 5 Pendir		e of injury h, Day,Year)	28b. Time o	or mjury		es 2 No	20d. Describ	e now inju	ary occurre	, u	
/iSiC	<u> </u>	2 Accident Investi 3 Suicide 6 Could	not be 28e. Plac	ce of Injury - A	t home, farm, st	reet, fa	tory, office bui	ilding, etc.			ind Numbe	er or Rur	al Route Number, City
Div Dital o	Certification:	4 Homicide determ		)					or Town	, State)			
	ਜ਼ੂ   ਤ	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsician: To the be niner:On the basis	of examinatio	ledge, death oc n and/or investi	curred gation,	at the time, date in my opinion, o	e and place, and death occurred a	I due to the ca at the time, da	iuse(s) an te and pla	id manner ace, and di	as state ue to the	ed. e cause(s)
To wit	Ĕ	29b. Signature and title of certifier	and manner s	stated.			29c. License						eth, Day, Year)
		Course	4aeo	an	-		O.C.M	I.E.		Dec	cember :	21, 20	10
0	1	30. Name and address of person v				· C:		MD 0400	.4	-			
			istant Medical					re, мр 2120 	1				
Stat Registra	-	31. Date filed (Month, Day, Year)	11 A-100	egistrar's Sig	ature back	11							

10-10026
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Jacqueline Marie Harvey

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	State of Maryland / Department of Health and Mental Hygiene	20	IU	1	13	1

		1 - For State Certificate of D			j. No.	
Physici		Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
fledical Exami	ner	Jacqueline M. Harvey  4a. Facility Name (if not institution, give street and number)  4b.	City, Town, or Location of Death	Month December 2	27, 2010 4c. County of Death	1434 hrs
			lavre de Grace	•	Harford	
Funeral		Social Security Number	f Under 1 Year If Under 24Hrs	s. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	
Director		007-38-4691 1_M 2XF 73 Yrs.	Months Days Hours Min	12/11/	1937 Foreig	n Intry) Maine
		Usual Residence of Decedent				
w an		10a. State 10b. County 10c. City, Town or Location		40		10d. Inside City Limits  1 Yes 2 No
aryland 8a-f show any at once,	tor	ME Kennebec West Gardin  10e. Street and Number	Of, Zip Code		a. Citizen of What Coun	
th the Maryland 23a or 28a-f sho notified at once.	Director			100		uyr
with the 18 23 a c noti			04345 ecedent of Hispanic Origin? ( S	pecify Yes or No-	U.S.A.	can Indian, Black,
death r item nust b	Funeral	1 Never Married 2 Married Armed Forces? If Yes,	specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Ye	s 2 No specify:		Specify:	Ihite
hours Fram			Usual Occupation (Give kind of voor of working life, DO NOT use reti		16b. Kind of Business/Ir	ndustry
5-0036 led within 72 ho Hygiene. tother than "na	Completed		. Assistant		New time A.	( J
5-0036 led within 7 Hygiene. I other than the Medica	Con	17. Father's Name (First, Middle, Last)	S Assistant 18.Mother's Name	e (First, Middle, Ma	aiden Surname)	_u
21, be fill rrked	Be	Carl Frost	Irene	Perkins		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must he notified at once	၉	/I	Idress (Street and Number or I			
and 2 shoul fealth and N tem 27 is n traumatic		Jessica Theriault (Daughter) 14 Spr. 20a. Method of Disposition 20b. Place of Disposition	ingvale Road, (	West Gard Date	diner, ME ( 20c. Location - City or	14345 Town, State
ages 1 nt of H it: If it		1 Burial 2 X Cremation 3 Removal from State crematory or other	place)			
Baltimore, permit. Pages 1 ar Department of Hec Important: If ite		4 Donation 5 Other Specify: R.A. Ferris 2 Signature of Funeral Service Licensee 22. Nam	& CoInc12/ e and Address of Facility Ze	29/2010	West Chesa	er, PA
Pen Ben B			S.Washington S			
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the n failure. List only one cause on each lipe.	node of dying, such as cardiac o	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease	se			Death
- July 1		or condition resulting in death)  Due to (or as a consequence of):				
" " Brand.	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	c. (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):				
uted Id ansit		events resulting in death) Last  Due to (or as a consequence of):  d.				
e exec cian ar rial - t	Medical	UNPENDED AMENDED				
760 icate b physi		IF FEMALE: 23b. Was decedent pregnant in the			23d. Date of delivery	
Box 687 death certifithe attending	Physician	past 12 months?	death 3Ectopic pregna (Specify)	ancy	Month D	ay Year
Boy death	ıysi	1 Yes 2 No 9 V Unknown 9 Unknown	(Specify)			
P.O. s that the gned by t	by PI	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		acco use contribute to t	
S, P.(	pe	Diabetes Mellitus; Strokes			2 No 3 Prob	
ord aw req	plet			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
Rec The I	Completed			perform 1 Yes 2		s 2 No
of Vital Records,  ig Physician: The law requir  the this certificate has been so  neral director, page 2 should	8	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	26.Place of Death (Check			
of V g Phys rer thii	음	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3  27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury			esidence 6 Other:	
OD Con cath.	Ę	Natural 5 Pending	1 Yes 2 No		,,	
Division tal or Attendi rs after death. al Director: A	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fa	actory, office building, etc.		reet and Number or Rur	al Route Number, City
Oj spital o ours al	Certification:	4 Homicide determined (Specify)		or Town, Sta	ite)	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation,				
5 1 8 1 8	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
		anex	O.C.M.E.		December 28, 20	10
		30. Name and address of person who completed cause of death (Item 23a)	( D.W			
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Stre  31. Date filed (Month, Day, Year) 32. Registrar's Signature	et, Baltimore, MD 2120	1		
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 7:15 PM<sup>M</sup> 2010 10, December Gwen Highto /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 72 River Oaks Circle Pikesville 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 8. Date of Birth (Month, Day, Year)
July 23, 1955 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs Funeral Months Days Hours 1 □ M 2 🖾 F 213-54-0667 55 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Eventine. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√☐ No Funeral Director Pikesville Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 USA 72 River Oaks Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) healthcare art therapist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marty Highto Geraldine Benstein ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 72 River Oaks Circle Pikesville, MD 21208 Joan Magill/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Sgnature of Funeral Servi 23a. P. t1. Enter the disc se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows, or heart failure. List only one cause on each line.

Immediate the e (Final disease or condition resulting in death)

a. Metas a 'Cancer'

Districtions a Condition resulting in death) Approximate Interval Between Onset and Death Physician 6 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to time solution cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a nonsequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed2 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 5:5 th's home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: /
filled in by the for 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ompleted cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

P.O. Box 68760,

Division of Vital Records,

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32. Registrar's Signature

Paul: Cr. 71 Sv. 12 415,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Harman Sharon Jean Medical Dec 2010 7:10 P M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6557 St. Helena Ave. Baltimore City N/A 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth 1 M 2 T F Months Hours (Month, Day, Year 216-54-2467 Director Oct 1949 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD N/A Baltimore City XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>6557 St. Helena</u> Avenue 21222 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Black, White, etc ģ Baltimore, Maryland 21215-0036 Yes 2 No Yes, Give 1 ☐ Yes 2 ☐ No Specify: 3X Widowed 4 ☐ Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany once. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Supermarket Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Kenneth Lee Andrews Clara Rose Tumblin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6557 St. Helena Ave. Baltimore, MD Crystal Shipley (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 12/29/2010 Towson, Maryland 21. Signature of Janeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Licha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ belastitie Onset and Death disease or condition resulting in death) Cancer 5MONTY - Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) 3 Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.
9 Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 0 No 1 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident Investigation 2 No completed filled in by the Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Leve 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PURTO 11 THBUML MILYAFEL 4940 EATTERY

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State Registrar 31. Date filed (Month, Day, Year)
JAN 0 3 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1:40 A RICHARD 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death COCKEYSVILLE BALTIMORE BROADMEAD If Under 1 Year Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F Months Days Min 0471871919 91 212**-**20**-**8545 MD Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD BALTIMORE COCKEYSVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? be items 23a oner must be Funeral 13801 YORK ROAD, #B-18 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" Specify. Completed 3 Widowed 4 N Divorced WHITE the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) COMPUTERS COMPUTER PROGRAMMER age 1 and 2 should be filed wit ont of Health and Mental Hygie it; If item 27 is marked other y or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ HUTZLER GRETCHEN HOCHSCHILD ALBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSEMARY HUTZLER/DAUGHTER 3413 PARKINGTON AVENUE, BALTIMORE, MD timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or or 1 XX Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) SINAI CONGREGATION 12/31/2010 BALTIMORE, MD of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STAGE RENAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Month Year Pregnant at time of death Day 1 Yes 2 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCER 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 Yes 2 No Yes 2 Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Tes မ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title o 29c, License number 29d. Date signed (Month, Day, Year) 050232

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAMIDI

JAN 0 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ becember 29, 2010 9:15 A M Katherine Elizabeth Hartlove Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Edenwald Baltimore Towson Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 6. Sex If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In yrs. last birthday) 1 🗆 M 2 🗶 F Days Min. 1272571917 Maryland 214-01-2165 93 Director Usual Residence of Decedent or 28a-f show 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland | Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1846 Glen Ridge Road 21234 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mustingly or other traumatic event, the Medical Examiner mustingly or other traumatic event, the Medical Examiner mustingly or other traumatic event, the Medical Examiner mustingly and the statement of the model of the statement of the 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Completed 3 ¥ Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ Frank E. Brown Katherine Elizabeth Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Webster / Sister 1705 Freeland Road Freeland, Maryland 21053 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial 12/31/2010 Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. w 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Int rval Between O set and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseq Examiner Secure tially list our differs if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a ysician and e burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ⊟ Fetai பகவ ☐ Pregnant at time of death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months

1 Yes 2 No

9 Unknown Month Day Year signed by the at the detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 Tes 2 🗌 No ieral Director: A filled in by the fu Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed t (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed, (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 v Physician/ Month Bessie Mae Jester 0429PM 2010 ecembe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Agnes Huspita Balt: more 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕅 F (Month, Day, Year) Director 226-36-7689 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If ifew 27.5 is marked other than "natural", or items 23a or 28a-f sho ury or or other traumatic event, the Medical Examiner must be notified at ury or or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21215 3609 Labyrinth Road, Apt. 2B USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black White etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: African-American 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th Baltimore City Public School Oistodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willie Hawthorne Ruby May Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Tanika Jester-Byrd/Granddauchter 1118 Sage Drive, York, PA 17408 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 1-4-2011 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Brooklyn, MD Signal re of Funeral Service Licenses Wylie Funeral Home P.A. of Balto. Co. 22. Name and Address of Facility 9200 Liberty Road, Randallstown, MD 21133 23a. Par 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscleratic Cardiovascular Dis ease MUNUM disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and hed for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown g Unknown seen signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I performed 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: ျ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 🔲 Yes Natural 5 Pendina 124 hours after death. Ie Funeral Director: A 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 0005814 December 26,2010 oce mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

ester

Avenue

32. Registrar's Si

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** M Mateo Orlando Jackson 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F Days Hours Min. Vrs **Director** Dec 17. infant MARYLAND Usual Residence of Decedent the Maryland or 28a-f show notified at 10a. State 10h Counts 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Ellicott City Howard 10e. Street and Numbe 10f. Zip-Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be no any injury or other traumatic event, the Medical Examiner must be no any injury or other traumatic event, the Medical Examiner must be no anne. 7778 Blueberry Hill LANE @!)\$# USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2X No 1 Never Married 2 ☐ Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 2 Specify black Specify: 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant infant 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be Monica Jackson ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ₩ Other (Specify) in state 21. Signature Funer I Struce Licensee <sup>22.</sup> Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or beart failure. List only one cause on each line. Immediate Caus (Final disease or condition resulting in death) **Physician** extreme prematurit /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tra that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Ectopic pregnancy signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 certificate has 2 No 1 Yes or Attending Physician; funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 🗌 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA မ 24 hours after death. Funeral Director; After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) Injury 1 Yes 2 No 2 completely filled in by the Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signature and title of certifier

State Registrar 30. Name and address of person

INDA

DHMH 17 Rev 1/2001

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's

29c. License number

066161

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

DECEMBER 19, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Medical cility Name (if not institution, give street and number Examiner 4b. City. Toy If Under If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth Age (In vrs. last birthday) Funeral 1 - M 2 - XF Months Days Director 220-82-948 48 Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD NA 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? with 1 23a Funeral 473 S. Augusta Avenue 21229 USA items ? within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. African þ 1 X Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: American Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) and Mental Hygiene. 2vrs. Supervisor State of Maryland is marked other Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Clarence Knox, Sr. Smallwood Margaret 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ${\sf Daughter}$ Health a item 27 other tra 5300 Beaufort Avenue 2nd. Fl. Baltimore, MD Aldreama McKnight 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date cemetery, crematory or other place. 1XXBurial 2 Cremation 3 Removal from State 12-30-10 4 Donation 5 Other (Specify) King Mem. Pk. Randallstown, 21. Signature of Funeral Service Lice see Wylie Funeral Home P.A. 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or comlications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List opt ne cause on each lit Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Economially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law equires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No fo ☐ Pregnant : 5 Other (specify) Month Day Year Pregnant at time of death Yes the detached 9 Unknown P.O. signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t autopsy certificat 25. Was case referred to medical examiner? Division of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 은 1 Yes 1 Inpatient 2 ER/Outpatient ΠOΔ 4 Nursing Home 5 Residence 6 Other (Specify) After this 27 Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending 1 Yes 2 🗌 No within 24 hours after death To the Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on the 29b. Signaru 29d. Date signed (Month. Day, Year)

Registrar

State

31. Date filed (Month, Day,

eath (Item 23a) (Type,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1.15 PM 12 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death Good Samaritan Hospital Baltimore N/A . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Year 953 1 ★ M 2 □ Director 215-64-9612 57 Mary Tand Usual Residence of Decedent 28a-f show perriit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Det artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at one. 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Baltimore Parkville 1 🗆 Yes 2 🔯 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8845 Wilson Ave. 21234 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc ò 1X Yes 2 □ No If Yes, Give Year or Dates. 1970–1976 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Medical Supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Kelly, Sr. Josephine Biedenback 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Ann Kelly / Wife 8845 Wilson Ave. Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 12/31/10 4 ☐ Donation 5 ☐ Other (Specify) Overlea, Maryland 1050 York Road 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? END STALLE RENAL DISEASE, DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown SACRAL DECUBITUS VICERS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 4 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Prostitioner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Gotting Nurse Practiciner: T. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Gotting Nurse Practiciner: T. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check MEDICAL-RESIDENT RESDOO

Registrar

DHMH 17 Rev 7/2009

5601 LOUIRAVENBLUD, BALTIMORE, MD-21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

PARANJI

SUCHITRA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ December 29°2010 7:00am Richard M Koogle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City Baltimore City 4310 Parkwood Avenue Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Month, Day, Yes Hours Arbutus, Maryland Director 220 36 3374 Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f shov dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1X Yes 2 No Baltimore Baltimore City Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21206 4310 Parkwood Avenue 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Industry Construction Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ruth Estelle Melvin Charles Koogle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4310 Parkwood Avenue Baltimore, Maryland 21206 19a. Informant's Name/Relationship (Type, Print) 4310 Parkwood Avenue Sharon K. Koogle (Wife) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Parkwood Cemetery January 3, 2011 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ig atu e of Funeral Service Dicenses 2. Name and Address of Eacility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the cashock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate nterval Between Onset and Death Immediate Cause (Final 45100 Priysician/ disease or condition resulting in death) Medical Estructive Pulmonary Disease Due to (or as a consequence of); Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) bstructiv or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No

9 Unknown Month Day Year Pregnant at time of death signed by the a Id be detached f Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated based based based and based should based and based and based are seen signatured based ompleted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed! Yes 2 No certificate 1 1 🗌 Yes 2 🗆 No hin 24 hours after death.

the Funeral Director: After this certific

mpleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2VI No 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) မ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manuer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury\_at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 Yes 2 No Investigation 6 Could not be Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

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complet 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certain . Date signed (Month, Day, Year) 30,2010

Registrar

State

31. Date filed (Month, Da

DHMH 17 Rev 7/2009

park

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Day Physician/ -unice Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** Baltimore Baltimore ane 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Months 1 M 2 F Director Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at **Funeral Director** zaltimore MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status th and Mental Hygiene. 27 is marked other than "natural", or itel traumatic event, the Medical Examiner Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Morgan State College (1-4 or 5+) Elementary/Seconday (0-12) Whi versity 12th grade Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ inadrick Hale lope tunico 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau I. Main Street Hampstead MD 210 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Woodlawn, MD 12010 Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Vauann C. Greene Fineral Services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility iberty Road Randailstown MD 21133 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Ph\_sician/ espival Medical resulting in death) Due to (or s a consequence of): **Examiner** Cance Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown Records. 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No **Division of Vital** 26. Place of Death (Check only one) Be Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Suicide Investigation after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by Homicide determined e Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 238 12/30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State JAN O. Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ົ້າ9, 201່ຶດ DECEMBER 0830 A M RUTH LOWMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL CROFTON CONVALESCENT CENTER **CROFTON** If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month Day, Year 1920 Months Days Hours Country) 1 🗆 M 2 Director 90 400.28.8155 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at ould be filed within 72 hours after death with the Maryland of Mental Hygiene.
marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2xx No LINTHICUM ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 MANSION RD-21090 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Force XX

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 XWidowed 4 Divorced WHITE if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ANNE ARUNDEL CO. SCHOOLS **TEACHER** 12 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည NANNIE SMITH BEN PRIDEMORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER Page 1 and 2 618 NEWFIELD RD. GLEN BURNIE, MD 21061 SUSAN A. KAMINSKI Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify CEDAR HILL CEMETERY 12.22.2010 BROOKLYN, MD Sign fe of Funeral Service 22. Name and Address of Facility FINK FUNERAL HOME, P.A. CRECORY 426 CRAIN HWY SW GLEN BURNIE, MD 21061 M01148 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final €hysician/ Medical resulting in death) Due to or as a consequence of Examiner Sequentially list conditions, Physician/Medical Examiner Due to for es a consecuence off if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) the detached 9 Unknown as been signed by 2 should be detact Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed' certificate 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No မ 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation after death the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d, Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) erson who completed caus 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10c-f. Per, FH G911 1/03/2011 JH State of Maryland 7 Department of Health and Mental Hygiene item 23apt.11 per me g924 2-16-12 vt/02/23/2012dhb

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OHavio Lorenzet Physician/ Month Year 35 6 M December 28 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ba1timore Seasons Hospice Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, ) Year) 915 Pennsylvania 217-09-0228 95 Yrs. Director Nov. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XX No MD Baltimore Reisterstown-Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4114 Westmeath RD. 21236 Funeral 811 Ivydale Ave. U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, . Was Decedent Ever In U.S.
Armed Forces?

XXI Yes 2 □ No 1945.
If Yes, Give
Year or Dates. 1946 Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes X No Specify: XX Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Brick1ayer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown ည Pietro Lorenzet Lucia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4114 Westmeath Rd. Baltimore, MD 21236 Steven Lorenzet / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Lake View

Memorial Park 1XXSurial 2 ☐ Cremation 3 ☐ Removal from State 1/3/11 Sykesville, MD 4 ☐ Donation ⊅ ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature Fy eral Solvice Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cardiornscular Disea Physician/ disease or condition resulting in death) Athenoschenone Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on. attending physician and for use as the burial-transil the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Right Hip Fracture 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page death? Yes 2 No 2 No 1 🗌 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No 4 Nursing Home 5 Residence 6 Other Specify Hospital: Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred Injury PM work?
1 Yes 2 No ☐ Matural Maccident 5 Pending fell in front of TV 12/18/10 Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 639 Main St 4 Homicide determined filled in by Reistusionn-MO. 21136 Assisted Living facility 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Uskajap Anem. D 00057465 12/29/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Ryapa Kryn 18355min N-5-203, Baltimor, MO. 21206 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 3 201 Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 30, Year 1 5:01A M Ε. Lavache Daniel Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Towson If Under 1 Year I If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Feb 8, 1 🖾 M 2 🗆 F Months Hours Day. Country) Yrs Director 022-10-4414 95 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits death with the Maryland the Medical Examiner must be notified at Funeral Director 1 Yes 2X No Owings Mills MD Baltimore 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? "natural", or items 23a 2049 Hunting Ridge Drive 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Page 1 and 2 should be filed within 72 hours after 1 Tes 2 X No Specify: Specify 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Accounting Exxon Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Daniel L. Lavache Josephine Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heatth a Important: If item 27 is any injury or other trat once. Daughter 9805 Windswept Court Owings Mills, MD 21117 Elizabeth L. Jackson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/11/11 Owings Mills, MD Garrison Forest Vet. 11824 Reisterstown Road 21. Signature of Funeral Ser/Ice Licenses 22. Name and Address of Facility Bun Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final PNEUMONIA Physician/ disease or condition resulting in death) 7 DAYS Medical Due to (or as a consequence of) Examiner I DAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence or) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [조 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Yes 2 No 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital s after death.

I Director: After this cend in by the funeral dire Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, . Manner of Death 28b. Time of Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) iniurv 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined

Division of Vital Records, P.O. Box 68760 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 053430 DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MARYLAND 21204 6701 STREET CHAN LIORTH CHAKLES 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Day Physician/ LUCAS Ugnie L 349 PM 28,2010 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death Randallstown HUXP. tal Baltimore Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral X** м 2 🗆 ғ Months Days 150-60-93 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No BALTIMORE lh D BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral 4.5,4 8015 D WOODGATE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: BLACK 1 Yes 2 No If Yes, Give 3 - Widowed 4 - Divorced Completed Year or Dates the Medical 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) CASINO COOK HOTEL -Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SEFFREY EDWARD LUCAS JR SAWYER MARGARET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21344 MARGARET PHIFFER
20a. Method of Disposition ct: BALTIMORE 8015 D WOODGATE MOHLER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State SEASIDE DERRICK C. JONES FIH, P.A. Donation 5 Other (Specify) 07/2011 CEMETER . Signature of Funeral Service Licenses 22. Name and Address of Facility The AUE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Appr imate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Jepsi's Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pheumon; a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L. Fetal deal Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😽 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag 2 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tes 2 XNo Other: 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🛮 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 9月12,195

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mikeia Lucas	S 1- For State Registrar	tate of Maryla		rtment of He tificate of De		lental H		20 eg. No.	10 4132	
Physician/ Medical Examiner	1. Decedent's Name (First, Midd	lle,Last)	Lu(	98			Date of Deat     Month     December		3. Time of Death 1103 hrs	
s 4	4a. Facility Name (if not institution 1709 Guilford Avenue		ber)		ity, Town, or Locat	tion of Death		4c. County of	Death (A	
Funeral Director	5. Social Security Number 214 - 94 - 1417	<u> </u>	Age (In yrs. Ias			Under 24Hrs lours Min.		th (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)	
Maryland 28a-f show any d at once. rector	Usual Residence of Decedent  10a. State  10b. County	NA	10c. City, 1	Fown or Location	rno	ی			10d. Inside City Limits 1 Yes 2 No	
the Maryland s nr 28a-f sho tified at once. Director	10e. Street and Number	suil df	and A	Are 101	. Zip Code 2/2	02	1(	og. Citizen of Wha	t Country?	
s after death with the Maryland rral", ar items 23a ar 28a-f sho niner must be notified at once. by Funeral Director		12. Was Dece Armed For 1 Yes orced If Yes, Give Year or Dates:	dent Ever in U.S ces? 2 No	If Yes, s	cedent of Hispanic pecify Cuban, Mex 2 No spe	ican, Puerto		14. Race - White, Specify:	American Indian, Black, etc.	
36 .n 72 hour nan "natu lical Exar pleted	15. Decedent's Education (Spe Elementary/Secondary (0-12)		11111	0 1	sual Occupation (G f working life. DO N			16b. Kind of Busin	ness/Industry Son Versity	
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked uther than natic event, the Medical To Be Comple	michael	LUC	cas	Louis	1	Voni	ta P	Maiden Surname)	ی	
MD 21 d 2 should 1 th and Men a 27 is man unmatic ev	19a. Informant's Name/Relations  DEVELS		brother	19b. Mailing Add		Number or F		ber, City or Town,	State, Zip Code)	
Baltimore, ME permit. Pages   and 2 s Department of Health a Important: If item 27 injury or other trauma	20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other S	_		ace of Disposition ematory or other pl		·	Date - 2-011		downe, MD.	
Baltin permit. P. Departme Importan injury or	21 Ignature of Funeral Service		uel	22. Name	and Address of Fa	icility	w Fa	S. Bal	is ct.	
Physician /Medical Æxaminer	23. Part. Enter the disease, or failure. List finly one cause Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	on each line.	oxide Intoxic onsequence of):	eation	ode of dying, such	as cardiac o	respiratory erre	st, shock, or heart	Approximate Interval Between Onset and Death	
), be executed ician and un'al - transit rdical Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):							
50, te be execut tysician and burial - tra	UNPENDED  IF FEMALE:	AMENDED 23c If yes ou	tcome of pregna	ancy				23d. Date of de	alivery	
). Box 68760, the death certificate by the attending physic ched for use as the burn Physiclan/Mec	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Un	1 Live birt	h nt at time of deat	2 Fetal de	_	topic pregna	ncy	Month	Day Year	
i, P.O. ires that the signed by the detached by the detached by the by the boundary and by PI	Part II. Other significant condit	ions contributing to c	leath but not res	ulting in the underl	ying cause given i	n Part I.		2 No 3	re to the cause of death?  Probably 4 Unknown	
Division of Vital Records, P.O. Box 68760, the Haspital or Attending Physician: The law requires that the death certificate be hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physici piptetely filled in by the funeral director, page 2 should be detached for use as the burilical Certification: To Be Completed by Physiclan/Med	25. Was case referred to medica				26.Place of De	ath (Check o	24a. Was a autops perform	sy prid med? dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 No	
F Vital Physician r this cert ral directo	examiner?  1 Yes 2 No	Hospital:	patient 2 E	R/Outpatient 3	DOA Other			Residence 6	Other: Scene	
ion of ttending Ph leath.  tor: After t the funeral ation: T	27. Manner of Death  1 Natural 5 Pend 2 Accident Inve	28a. Date of FOUND: The stigation Dec 28, 20	ay,Year)	28b. Time of Injury FOUND: 1103 hrs	ury 28c. Injury at Work? 28d. Describe how injury occurred Subject inhaled CO					
Division o  To the Enspital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune ledical Certification:	3 Suicide 6 Couldete	d not be	of Injury - At hom Townhouse					28f. Location (Street and Number or Rural Route Number, City or Town, State) 1709 Guilford Avenue, Apt. B, Baltimore , MD		
To the Hns within 24 h To the Fur completely		hysician: To the best of miner:On the basis of and manner stat	examination and							
) v	29b. Signature and title of certifie	er			O.C.M.E.	ber		29d. Date signed December 29	(Month, Day, Year) 9, 2010	
	30. Name and address of person Ana Rubio MD. Ass	who completed cause sistant Medical Ex			e Street, Balti	more, MD	21223			
State Registrar	31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	Kal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month CATHERINE ELLEN PAGE MUNGER December 2010 10:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2106 Chapelwood Court Lutherville Baltimore County Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth
Dec 3, 1908 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Days New York 213-66-5898 Yrs Director 102 Usual Residence of Decedent or 28a-f shov 10a. State Iral", or items 23a or 28a-f sho | Examiner must be notified at 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore County Lutherville 10e. Street and Number 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important if filem 27 is marked other than "-- any injury or other traumation." Funeral 2106 Chapelwood Court 21093 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Homemaker Own Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Page Anna Harris 19a. Informant's Name/Relationship (Type, Print) (Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charmaine Rogers-McGilveary 519 North Potomac Street, Baltimore, Mryland 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grandview Cemetery 1/7/2011 Batavia, New York 21. Signature Control of Records 22 Name and Address of Eaching MITCHELL-WIEDEFELD FUNERAL HOME, IN 6500 York Road, Baltimore, Maryland Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or less iratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine tany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year the funeral director, page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation To the Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number determined 24 hours Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Nonth, Day, Year) 30

DHMH 17 Rev 7/2009

State Registrar ar's Signature

1447 York Road, Suite 605, Lutherville, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Stoltz, MD,

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Dennis Guy Myers 12:45P M 2010 29 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Maryland Masonic Home Cockeysville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 95 214-01-0660 July 18,1915 Maryland Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11203 Keysville Rd. 21787 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Completed by Specify White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) carpenter construction 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked t any injury or other traumatic ewone. Guy A. Myers Bessie Green 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Valentine/ daughter 11203 Keysville Rd. Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Deer Park Cemetery 1/3/2011 Smallwood, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signus of Foneral Service Lice aMaria 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stag **Physician** year disease or condition resulting in death) Enel /Medical Due to (or as a conse vence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Liter orderlying Cause (Disease or injury Due to (or as a consequence of): Examiner the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an page 2 s autopsy performed? Yes 2 No 1∐ Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2∏No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

The law requires that the death certificate be executed or Vital Records, P.O. Box 68760, Physician: or Attending after death. within 24 hours a To the Funeral I To the Hospital

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

ROBERT

Bank St.

29c. License number

29d. Date signed (Month, Day, Year) 12-30-10

and manner stated

3,008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIBERTO,

10-09496	
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	Edward	Lee	Mitchell,	Sr.
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	1- For State Registrar		Certific	cate of l	Death		F	Reg. No.	
Physician	1. Decedent's Name (First, Midd	ile,Last)					Date of Dea     Month		3. Time of Death
Medical Examine	Edward Lee N	Mitchell S	r				Decembe	Day Yea er 10, 2010	" 1233 hrs
	4a. Facility Name (if not instituti	on, give street and nu	ımber)	4b	. City, Town, or L	ocation of Dea	th	4c. County of	of Death
	1414 John Street				Glen Burnie			Anne Ar	undel
<b>Funeral</b>	5. Social Security Number	6. Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Year	If Under 24H	rs. 8. Date of B	irth (MM/DD/YYYY	9. Birthplace (State or
Director	217-20-1449	1XM 2_F	0 /.	Yrs.	Months Days	Hours M		1006	Foreign Country)
	Usual Residence of Decedent	, <u>M</u>	84	110.			Jan 2	. 1926	Country) Maryland
any	10a. State 10b. County		10c. City, Town	n or Location	1		·		10d. Inside City Limits
<b>*</b> .	_ MD Ann	e Arundel		Glen B	umni o				1 Yes 2 No
ylanc ylanc	10e. Street and Number	e Alunder			10f. Zip Code			10g. Citizen of Wh	71
the Marylanc a or 28a-f sh	1414 John Str	00+				1061	ļ	-	nat Country?
th the Maryland  23a or 28a-f sho motified at once		eet			2.	1061		USA	
r death with or items 23	11. Marital Status	4	cedent Ever in U.S.		Decedent of Hispa , specify Cuban, I			o- 14. Race White	- American Indian, Black,
or it	1 Never Married 2 N	1 X Yes	2 No				, , ,		,,
4 L9 >	3 🔍 Widowed 4 📗 Di	vorced If Yes, Give Yes or Dates:	44- 40	_	es 2 No			Specify:	black
5-0036 led within 72 hours a lygiene. Inther than "natura the Medical Exami	15. Decedent's Education (Spe			Decedent's during mos	Usual Occupation	n (Give kind of DO NOT use re	f work donank	16b. Kind of Bus	siness/Industry
6 27 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Elementary/Secondary (0-12)	College (*	-4 or 5+)				,	ĺ	
5-0036 ed within 72 hour lygiene. Inther than "natu the Medical Exan	10		0					cler:	
15-003 lled withi Hygiene. If anther the the Med		, Last)			18	3.Mother's Nam	ne (First, Middle,	Maiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked uther than ic event, the Medica		e11					Goldsbo		
L should and Mei	19a. Informant's Name/Relations	ship (Type, Print )	19	b. Mailing A	ddress (Street	and Number or	Rural Route Nur	mber, City or Towr	n, State, Zip Code)
e, MD  I and 2 sho Health and item 27 is	Edward L. Mit	chell Jr/s	son					imore, M	
S l ar of Hea If Hea	20a. Method of Disposition  1 Burial 2 Cremation	n 3 Pemoval fr		of Disposition	on (Name of ceme place)	etery,	Date	20c. Location -	City or Town, State
imore, MD 2 Pages 1 and 2 shour ment of Health and Nant: If item 27 is n or other traumatic	4 X Donation 5 Other S	_	om State						
Baltimore, permit. Pages 1 a Department of He Impurtant: If ite injury or other to	21. Signature of Fun	dicenter 1	Director	82-Na	ne_and_Address.co	f Eacility oar	d 655 W	Raltim	ore Street
E P P W	semma!	7/10/	Freetor		imore,	•		· Darern	010 001000
Physician	23a. Ant I. Enter the disease, or		aused the death. Do n					est, shock, or hea	
/Medical	falure. List only one cause	Hoad I	njuries						Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)	и	consequence of):						
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red Insit	events resulting in death) Last	Due to (or as a	consequence of):						
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8760, ifficate bug physic is the bug	IF FEMALE: 23b. Was decedent pregnant in the		outcome of pregnancy			1_		23d. Date of	
	past 12 months?	I Tive p	irth ant at time of death			Ectopic pregn	ancy	Month	Day Year
Box 687 to death certific the attending produce as the attending produce as the attending produced for	1 Yes 2 No 9 Uni	known 9 Unkno		5 Other	(Specify)			İ	
D. Box 68 true death certile by the attendinached for use a Physicial	Part II. Other significant condit			a in the und	eriving cause giv	en in Part I	23e. Did to	obacco use contrib	oute to the cause of death?
that oped of deta		<b>3</b>		· · · · · · · · · · · · · · · · · · ·	,				Probably 4 Unknown
aquires en signald be							24a. Was		Vere autopsy findings available
of Vital Records, ng Physician: The law require. The the require the certificate has been signeral director, page 2 should be not To Be Completed							autop	osy pr	rior to completion of cause of
Rec The la cate h							1 <b>✓</b> Yes		eath? ✓ Yes 2 No
tal Rectan: The certificate ector, page	25. Was case referred to medica	1			26. Place of	f Death (Check	only one)		
Vita hysicia this ce Il direc	examiner?	Hospital: 1	npatient 2 ER/O	utpatient 3	DOA O	ther Nursi	ng Home 5	Residence 6	Other: Scene
After the funeral	27. Manner of Death	28a. Date		Time of Inju	ry 28c. Injury	at Work?	28d. Describe	how injury occurre	ed
– ਜ਼ੈੂ ^ ਫ਼ੀ ਨ	1 Natural 5 Pend		/2010   12	:20pm und	1 Ye	s 2 X No	subject	fell at	home
Sior Attender death rector: by the	2 X Accident Inve	stigation Found 28e. Place	e of Injury - At home, fa		factory, office buil	Iding, etc.	28f. Location (	Street and Number	r or Rural Route Number, City
Division (spital or Attendin nours after death. oeral Director: Ar filled in by the fur Certification	3 Suicide 6 Coul		house		•		or Town, S	State)1414 J	ohn Street
0~ 10	29a Centiler .			ath accurra		and place on	<u>  Raltimo</u>		on stated
Division  To the Bospital or Attent within 24 hours after death To the Fuoeral Director: completely filled in by the	(Check only Certifying P		t of my knowledge, de of examination and/or i						
To the H within 24 To the F completel	29b. Signature and title of certifie	and manner s	tated.		29c. License r				d (Month, Day, Year)
-	Wa d	11			O.C.M.			December 1	
	Willyante In	e Inell			U.C.IVI.	.C.		December	11, 2010
	30. Name and address of person			444.5	0				
1									
State	Margarita Korell MD.  31. Date filed (Month, Day Year)		fical Examiner gistrar's Signature	111 Pen	n Street, Ball	tímore, MD	21201		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 amend #2 state of Maryland / Department of Health and Mental Hygiene 10-09090 Joseph Daniel McCaffrey Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 27, 2010 1000 hrs Medical Examiner Joseph Daniel McCaffrey 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 2454 Greenmount Avenue **Baltimore** 5. Social Security Numberunk 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Country) Months Hours Director Sept 4, 1958 52 1 X M 2\_\_\_F Yrs Usual Residence of Decedent 10d. Inside City Limits ALII 10a State 10b. County 10c. City. Town or Location 1 Yes 2 No 28a-f show other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once. Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, "natural", or items 23a or 28a-f sho or other Traumate other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2454 Greenmount Avenue 21218 USA Funeral nnk 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc unk Never Married Yes No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify white à 16a. Decedent's Usual Occupation (Give kind of work done unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 100 Penn Street Baltimore, MD 21201 O.C.M.E. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Itimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department mportant; Donation 5 V Other Specify 22 Name and Address of Facility Board 655 W. Signature of Funeral Service Licensee Ronald S Wade Baltimore Street @:001 MD Baltimore. t I. Enter the disease, or complications that caused the death. the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure List only one cause on each line. /Medical Alcoholism Immediate Cause (Final disease ≟xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical attending physician a or use as the burial -X UNPENDED AMENDED 23a,pt.II,27 per me g913 3-25-11 vt Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for 9 Unknown s been signed by the should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò Atherosclerotic Cardiovascular Disease, Asthma pleted 24a. Was an performed? this certificate has death? Com ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) director, 25. Was case referred to medica BB examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ✓ Yes No funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending 1 Yes 2 No

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✔ No 3 Probably 4 Unknown 24b, Were autopsy findings available prior to completion of cause of 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi Nursing Home 5 Residence 6 🗸 Other: Scene Certification: filled in by the Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. November 28, 2010 Soull )Merite 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signature State Registrar **ÓRIGINAL** 

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unk

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Death

Year

			1 - State of Maryl Registrar	•	rtment of Health a tificate of Death	ınd Mer	ntal Hygien Reg. No	2011	41334
	Physicia	an	Decedent's Name (First, Middle, Last)	M	104		Date of Death Month / Da	av Year	3. Time of Death
Mary Service	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	1/	4b. City, Town, or Location of		/	30 2010 c. County of Death	10.50 PM
A. S.		e i	Riverview Narsing Home And		Essex		1.	BAltim	ONE
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In )	yrs. last birthday) Yrs.	If Under 1 Year If Under 2 Months Days Hours	Min. NC	Date of Birth Month, Pay, Year VCMh CC 5	9. Birth Co. MAR	place (State or Foreign intry)
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c.	. City, Town or Loc	cation	-			10d. Inside City Limits
	e Mar) Ba-f sh	Director	Maryland Baltimone	ESSEX					1 ☐ Yes 2 Ø No
	with th	I Dire	10e. Street and Number 1 FASTERN Blvd. Ess		10f. Zip Code		10g. C	itizen of What Co.  U. S. A.	intry?
	r death	Funeral	11. Marital Status  12. Was Decedent Ever i Armed Forces?	n U.S. 13. V	Vas Decedent of Hispanic Orig Yes, specify Cuban, Mexican,	in? (Specify	Yes or No-	14. Race - Amer Black, White	
036	be filed within 72 hours after death with the Maryland the Hygiene. A content han "natural", or items 23a or 28a-f show event, the Madical Evantina must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		☐Yes 2 No Specify:		,	Specify: Wh	
15-003	"natur	leted	15. Decedent's Education (Specify only highest grade completed)	ı (Give l	lent's Usual Occupation kind of work done during most ( DO NOT use retired)	of working	16b. 1	Kind of Business/I	ndustry
2121	d withir giene. er than	Completed	Elementary/Secondary (0-12)  College (1-4or 5+)	4.4	e Maken		0	ON HOA	46
Maryland	be od o	Be	17. Father's Name (First, Middle, Last)	Lisak	18. Mother	r's Name (Fi	rst, Middle, Maide	n Surname)	* K
ary	d 2 should be th and Mental the marked of traumatic ev	욘	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street and Number	r or Rural Ro	oute Number, City	or Town, State, Z	ip Code)
	s 1 and 2 f Health Item 27 i		GERALdine Leffman  20a. Method of Disposition  20	the Place of Dispos	IPPER ROAC		SEAL M	ARYIANA Location - City or T	1 2 12 21
	m O L		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crem	natory or other place) ; 🚁	WYARY	4.	dally, M	
Balt	permit. Page Department Important: If any Injury o		21. Signature of Funeral Service Licensee	22 W	. Name and Address of Facility	chej N	ACK! FUR	VERAL HEM	es P.A.
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	death. Do not ente	er the mode of dying, such as o	cardiac or re	spiratory arrest,	MARYLANT	Approximate Interval Between
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	end	failure	_			Onset and Death UM - KNOWN
A. I	Examiner		Due to (or as a con	sequence of):					
7	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter brusenying Cause (Disease or injury	sequence of):				19	
oʻ	icate be executed physician and the burial-transit		that initiated events c. Due to (or as a con	sequence of):					
		dical	d						
Box	death certifi attending for use as	an/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □		Ectopic pregnancy			23d. Date of deli	very
О. В	The law requires that the death certifiate has been signed by the attending bage 2 should be detached for use as	Physician/Me	in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown	of death 5	Other (specify)			Month	Day Year
s,	w requires that the de been signed by the s should be detached	by Pr	Part II. Other significant conditions contributing to death but not	4 /	1				the cause of death?
ord ord	v requir been s should	eted	- Hypery	ian H	you des	-	1 🗆 Yes		obably 4 Unknown
Division of Vital Records,	sician; The law certificate has b irector, page 2 sl	Completed					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
VITa	ician; certific ector, l	Be	25. Was case referred to medical examiner?		100		heck only one)		
סר	g Physter this	n: To	27. Manner of Death 28a. Date of Injury	2 ER/Outpatien 28b. Time of	IT 3 DOA 4 ALPNur		5 Residence  Describe how inj	6 ☐ Other (Specury occurred	cify)
Sior	tendin leath. tor: Aff the fur	catio	1		M 1 □Yes 2 □N				
D V	tal or At s after o al Direc ed in by	Certification:	4 Homicide determined 28e. Place of Injury - / building, etc. (St	At home, farm, stre secify)	eet, factory, office	28f.	Location (Street a City or Town, Sta	and Number or Ru ite)	ral Route Number,
;	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certified completely filled in by the funeral director, p	cal	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or inv	vestigation, in my opinion, deat	th occurred a	at the time, date a	ind place, and due	to the cause(s)
	vithin To the comp.	Me	29b. Signature and title of certifier		29c. License number	10/L	29d. D	Date signed (Month	n, Day, Year)
			30. Name and address of person who completed cause of death	(Item 23a) /Tyne	$y - 3\sigma$	124	(2	2-31-	2010
			and manner stated.  29b. Signature and title of certifier  30. Name and address of person who completed cause of death  MALIKA WASELM TO  31. Date filed (Month, Day Year) 0 3 201 132. Recistrar's S	9. BA	STERN &	SLVD	- M	D-2	21221.
	Sta Registr	te ar	JAN 0 3 2011 22. Hedstrars S	igriature A.	garke				

DHMH 17 Rev 1/2001

Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital within 24 hours after death.

To the Funeral Director: A completely filled in by the fun

1 🗸 Yes

2 No

28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? 27. Manner of Death Driver in vehicular collision FOUND: 1 Natural 1 Yes 2 ✔ No 5 Pending Dec 31, 2010 1530 hrs 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide or Town, State) Route 70 WB at Bethany Lane, Ellicott City, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other Nursing Home 5 Residence 6 Other: Scene

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

January 1, 2011 O.C.M.E.

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

30. Name and address of person who complete cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD.

31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 23b per doc e911 1-28-11 yt
State of Maryland / Department of Health and Mental Hygiene? For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28 2010 Month M 980. **Physician** 161 0-Uscomber /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner **Baltimore City** N/A The Johns Hopkins Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 X M 2 □ F Days Hours Yrs 75 09/04/1935 Director 218-30-1443 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. and the T7 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2X No Director MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 4922 RIDERS COURT 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 Specify 3 ☐ Widowed 4 ☐ Divorced WHITE Completed permit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natur
any injury or other traumatic event, the Medical
once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) NAVIGATION AID TECHNICIAN AIR FORCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EVERETT MURPHY ELIZABETH BONNER မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEANNETTE MURPHY/WIFE 4922 RIDERS COURT, OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MARYLAND VETERANS 01/06/2011 OWINGS MILLS, MD 21. Signature of Funeral Service Lig 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration **Physician** disease or condition resulting in death) neumonia Medical Due to (or as a consequence of) Examiner Parkinson's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a purse quence of The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only of Be examiner? Other: 4  $\square$  Nursing Home Hospital 1 ☐ Yes 2 No 1 Xnpatient 3 □ DOA 2 ER/Outpatient 5 Residence 6 Other (Specify) မ Director: After this 27. Manner of D th Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: i Natural 2 Accident Attending (Month, Day Year) 5 Pending Injury 1 🗌 Yes investigation 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (check only one) Sompletely and manner stated 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 26,2010 ecenn Ner of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Hayes 600 North Wolfe St, Baltimore, MD, 21287 argaret 31. Date filed Month, Day, State JAN 03 2011 Registrar

DHMH 17 Rev 1/2001

		1 _ State	Maryland / Dep	partment of Hea			701	0 41337
		Registrar  1. Decedent's Name (First, Middle, Last)		- Tillicate of Dec	<u> </u>	2. Date of Dea	Reg. No.	3. Time of Death
Physicia		ANNETTE MORS	TRIN			Month	Day Yea 26	1 /000
Medi		4a. Facility Name (if not institution, give street and numb		4b. City, Town, or Loc	cation of Death	Dec	4c. County of Do	
Examir	ier		d92		esvile	,		7011
Funeral	_		. Age In yrs. last birthday,	// 10	Under 24 Hrs.	8. Date of Birtl		Birthplace (State or Foreign
Director		505-20-9507 1 DM 2 X F	87 Yrs.		lours Min.	(Month, Day		Country) NE
*	1	Usual Residence of Decedent				3014	7 74	
sho dat	호	10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
Many 28a-i otifie	Director	MD BALTIMORE	LUTHE	RVILLE				1 🗆 Yes 2 😾 No
a or be n		10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
s 23	Funeral	504 LIMERICK CIRCLE, #2	:01	21093			USA	
death item		11. Marital Status 12. Was Deced	ent Ever in U.S. 13	. Was Decedent of Hispa If Yes, specify Cuban, M	nic Origin? (Spec lexican, Puerto F	cify Yes or No-		merican Indian,
affer ", or amil	by	Armed Force  1 Never Married 2 Married 1 Yes 2  If Yes, Give	No No	1 ☐ Yes 2 ☐XNo S		,	Black, W	
al Ex	ompleted	3 Ky Wildowed 4 □ Divorced Year or Date						WHITE
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ithin ene.	S	Elementary/Seconday (0-12) College (1-4	or 5+)	DO NOT use retired) OMEMAKER			OWN HON	(C
Hygiv Hygiv ent, t	Be (	17. Father's Name (First, Middle, Last)			Mother's Name	(First Middle I	Maiden Surname)	16
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2 should th and Me 27 is mar traumati		19a. Informant's Name/Relationship (Type, Print)		iling Address (Street and		Pauta Numbar		
2 sh Ith ar 27 is		SUSAN SPIVEY/DAUGHTER	1.3	1 W. PADONI				
and 2 s Health Item 27		20a. Method of Disposition	20b. Place of Disp			late	20c. Location - City	
Page 1 ment of ant: If it		1 Burial 2 Cremation 3 Removal from S	tate cemetery, cri	ematory or other place)			_	
permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tr		4 Donation 5 Other (Specify)  21. Singur, if Funeral Service dicens s		E HEBREW CE 22. Name and Address of				STOWN, MD
permit. Departn Importa any inju	1	MINION KIND		8900 REISTE	50.		SON & BROS	
_		23a. Part 1. Enter the disease, or complications that ca	used the death. Do not er					Approximate
Ph sician/	١.,	shock, or heart failure. List only one cause on each Immediate Cause (Final	i line.	J. Span	02	enal		Interval Between Onset and Death
Medical		disease or condition resulting in death)  a. Due to (or	as a consequence of):	14	Don	116		years
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	iner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying	as a consequence on.					
ecuted and I-transit	Examiner	Cause (Disease or iinjury that initiated events c.						
exectan ar	<u> </u>	resulting in death) Last Due to (or	r as a consequence of):					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral after death.  To the Funeral inferetor: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	d			_			-
rtifica ing p	Physician/Me	IF FEMALE:						
th ce	ian	in the past 12 months?	ome of pregnancy irth 2  Fetal death 3				23d. Date of	
dea the a	ysic	1 Yes 2 760 4 Pregna 9 Unknown 9 Unknown		Other (specify)			Month	Day Year
at the		Part II. Other significant conditions contributing to dea	ath but not resulting in the	underlying cause given i	in Part I.	23e Did to	hacco use contribute	to the cause of death?
es th	l by		an Dat Hot Toodining III and	andenying sauce given				Probably 4 Unknown
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law r has b e 2 sl	ld I				<del>.</del>	24a. Was a autop	sy prior	autopsy findings available completion of cause of
The cate page	ပိ						med? death	? Yes 2 □ No
cian: ertific	Be	25. Was case referred to medical examiner?			of Death (Check	only one)		
hysi this o	P	1 □ Yes 2 ☑ NO 1 □ Ir	patient 2 ER/Outpati		4 Nursing Hor	me 5 🗌 Resid	ence 6 Other (Sp	ecify)
After After Tuner	ate	27. Manner of Death 28a. Date of 1 Natural 5 Pending (Month	injury 28b. Time , <i>Day, Year)</i> injury	work?		8d. Describe h	ow injury occurred	
tend death tor: /	iji	2 Accident Investigation 3 Suicide 6 Could not be			2 🗆 No			
or Ail after a Sirec	Certificate:		f Injury - At home, farm, s , etc. <i>(Specify)</i>	treet, factory, office	]	28f. Location (S City or Tow	treet and Number or . n, State)	Rural Route Number,
pital cours are filled		29a. Certifier 1 Certifying Physician: To the bes	et of my knowledge, deat	occured at the time, dat	to and place, and	due to the car	social and manner an	etatod
Hos 24 h Fun	Medical	(Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practioner: To	of examination and/or inve	estigation, in my opinion, d	leath occurred at	the time, date a	nd place, and due to the	ne cause(s) and manner stated.
orthin orthic	2	29b. Signature and title of certifier	the best of my knowledge	29c. License nur			29d. Date signed (Mo	
F > F 0		pull	NO		9943			27,200
		30. Name and address of person who completed cause	of death (Item 23a) (Time		-		1	
		Inn ( Avel me 295	4	- Suite 3	مدر را	5 min	ster mu	27157
Sta	te		gistrar's Signature	- '	1	1	-	1 1 2 7
Registr		JAN 0 3 2011 /2	1 back					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mills Physician/ Richard Month 2 1533 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltmeire Lend N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 🖾 M 2 🗆 F Hours M17707/1945 Virgin<u>ia</u> Director 214 42 3929 65 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Machinal 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Baltimore 1 Yes 2 No 10e, Street and Number 10g. Citizen of What Country? Funeral 614 Nautilus Avenue 21225 U.S.A. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Arch. of Baltimore Elementary/Seconday (0-12) College (1-4 or 5+) Teacher 4 + Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Mills Rita A'Hearn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Mills / Wife 614 Nautilus Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 12/23/2010 21. Signature of Juneral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final (ardspul monary Physician/ Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** weeks Sequentially list conditions. Examine cause. Enter Underlying Month o Valve After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Mostletic valve 1 Tes 2 No 3 Probably 4 Unknown Completed endocarditis 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ပ္ 1 Yes X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number FM1222316 21 2010 completed cause of death (Item 23a) (Type, Print)
mat MD 22 South. Greene St. Baltimore, MD 30. Name and address of person who Mattemat 31. Date filed (Mo State Registrar

10-09998	
Roland L.	Mitchell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 26, 2010 2225 hrs Roland L. Mitchell Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Good Samaritan Hospital N/A 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Foreian Months Davs Hours Country) Maryland 217 38 1588 Director 67 1 XM 2 F 03/03/1943 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 X Yes 2 No N/A Baltimore Maryland or 28a-f show notified at once. death with the Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 4129 Audrey Avenue 21225 靣 123a Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 1 X Yes 2 No White 1 Yes 2 X No specify: . Pages 1 and 2 should be filed within 72 hours after of timent of Health and Mental Hygiene.

Trant: If item 27 is marked other than "natural", in or other traumatic event, the Medical Examiner in or other traumatic event, Specify 4 Divorced If Yes, Give Year 1960-1963 þ 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Extrusian Inc. Die Repairman Specialist 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Lloyd Mitchell Jr. Eva Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21225 Michael Mitchell / 4129 Audrey Avenue 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 12/31/2010 Baltimore, Maryland 4 Donation 5 Other Specify: 22. Name and Address of Facility Gonce Funeral Service, P.A 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 come nanciall 23a. Part I. Enter the disease, promplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician een Onset and failure. List only one cause on each line /Medical Death a Complications of Peripheral Vascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED physician a AMENDED The law requires that the death certif cate be of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23h Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year attending p 2 past 12 months Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown signed by the the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown \$ End Stage Renal Disease Completed 24b. Were autopsy findings available 24a. Was an been prior to completion of cause of autopsy performed? death? certificate has 2 No Yes Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 AOD [ this 1 🗸 Yes ΠNο ၉ 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification 1 🗸 Natural 1 Yes 2 No Division 5 Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be 3 Suicide or Town, State) within 24 hours a Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 28, 2010 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner 31. Date filed y month, Day Year) 32. Registrar's Sign State

DHMH 17 Rev 1/2001 OCME 2006

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:30 A M Lena Ida Mrozinski 2010 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A304 S. Duncan Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Maryland 04/13/1920 1 □ M 2 🖫 F 90 212-07-9002 Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 XYes 2 ☐ No Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21231 United States 304 S. Duncan Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ▼ No Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic 6 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Lillian B. Clark Harry Nordbruch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 760 Kendale Road Red Lion, Pennsylvania 17356 Patricia Mack - Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/29/2010 Baltimore, Maryland Oak Lawn Cemetery 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Signature of Funeral Service Licensee Maryland 21231 Part J. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cance Physician/ Decas disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be det ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Tes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work?
1 Yes 2 No Natural 5 Pending s after death. Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United States of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tit D0033847 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tests Baltinon 32. Registrar's Sanature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 13, 2010 3:50 AM M Elizabeth D. Nash Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery National Lutheran Home Social Security Number . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Mar 3, Day 1930 Days Hours Mary Tand 80 Director 213-26-5144 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 Yes 2 X No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ems 23a or r must be r Funeral 20850 USA 9701 Viers Drive items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ö 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: white If Yes Give "natural", Completed 3 Widowed 4 N Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation un 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. sant: If item 27 is marked other than ury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) day care giver 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edna L. Vebel <u>George W. Danson</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5918 Taneytown Pike Taneytown, MD David Nash/son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signature of Fineral Service L S. Wade <sup>22</sup> State Anatomy Board 655 W. Baltimore Street Raltimore 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on caused the deat / Do not enter the mode of dying, such / cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 9 Unknown 2 🖼 No 9 Unknown detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work' 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1 🔛 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check oply one Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 3 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. V)

. Registrar's Signature

/32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle, Last). 3. Time of Death Physician/ 121/25/2010 2045 P Medical 4a. Facility Name (if not institution, give street and number)
115 Bloomsbury Avenue 49. County of Death 4b, City, Town, or Location of Death Havre de Grace **Examiner** 5. Social Security Number 6. Sex. 1 🖾 M 2 🗆 F 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 1 (M971/15) 14 1944 Martireand 219-42-9928 67 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Directo Baltimore, Maryland 21215-0036 OWENHavre de Grace Maryland Harford 1 No Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 21078 Completed by Funeral 115 Bloomsbury Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify. If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Painting Painter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Edna Florence Johnson ပ္ Paris Leonard Owen 19a. Informant's Name/Relationship (Type, Print) Larry C. Owen, Jr. (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 734 Aiken Avenue, Perryville, Maryland 21903 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
RA Ferrus aCoInc. 20c. Location - City or Town, State WestChester, Pennsylvania 12/30/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 Signature of Funeral Service Licensee 123 S Washington St, Havre de Grace, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ etastatic arcinoma OUC-LIERLY Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗷 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 🗌 Yes 2 II No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29d. Date signed (Month, Day, Year) 29b. Signatu and title of certifier 29c. License number December 29th. 2010 0 45390 Name and address of person who completed cause of death (Item 23a) (Type, Print)

140 Min (N. ). 602 South Atwood Good # 200, Bel Air 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Funeral		Social Security Number	6. Se		,	n yrs. last bii —	rthday)	If Und	er 1 Year	If Under Hours	1.00		,		Foreig	nplace (State or	
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ryland	10	Oe. Street and Number	JIIIU.	re cres			Dair	10f. Zip		, у			10g. C	itizen of Wh	at Coun	try?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	L	4222 Stanwoo	vA b							1206				USA			
th with the state of the state	1	Marital Status     Never Married 2	Married	12. Was De Armed F		er in U.S.									- Amerio , etc.	an Indian, Black,	
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5-0036 ed within 72 hours afti ed within 72 hours afti other than "natural" the Medical Examine Completed by		15. Decedent's Education (S		or Dates:		ted) 16a	. Decedent'	s Usual	Occupatio	n (Give ki			16b.	Kind of Bus	siness/Ir	ndustry	
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036 ithin sie.		9 yrs.		N/A			Serve	er						cDonal			
5-0 iled w Hygic the I	[ 17. Father's Name (First, Middle, Last) 당 및 William Mayo DeFord								18			First, Middle,		n Surname)			
121 d be fill fental F fental F cvent, d		WILLIAM May O  9a. Informant's Name/Relati				110	h Mailing	Address	/Street			y Diet		City or Town	State	Zin Code)	_
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple	Antonio G. Occorso (Son) 8374 Kavana							ress (Street and Number or Rural Route Number vanagh Rd. Dundalk, Md.									
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Physician Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrefailure. List only one cause on each line.								rest, sl	hock, or hea	ırt	Approximate Interval Between Onset and					
<b>Examiner</b>		Immediate Cause (Final disease or condition resulting in death)  a Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):								_	Death	_					
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the death certiful the death certiful by the attending sched for use as Physician	1		Unknowr			e of death	5 Oth	er (Spe	cify)								J
the de ched f	┝	art II. Other significant cor	ditions			ut not resulting	na in the ur	derlying	cause giv	en in Par	t I.	23e. Did	obacc	o use contrit	oute to t	he cause of death?	_
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Records, I The law requires fricate has been sig , page 2 should be Completed												24a. Was				opsy findings available	е
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ificate		5. Was case referred to med	ical I						26.Place o	of Death (	Check on		2 🗸	NO 1	Ye	2 No	_
fital sician sician is certificated	i	examiner?	_ <u>_</u>	lospital: 1	Inpatient	2 ER/0	Dutpatient			4		Home 5	Resid	dence 6	Other:	Scene	
of Vig Physical distributions of The Control of The		1 Yes 2 No 7. Manner of Death		28a, Date	e of Injury	28b	. Time of In	ury	28c. Injury	at Work?	2	8d. Describe	how in	njury occurre	ed		_
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Divis  Bospital or A 24 hours after Runcral Directely filled in b	4 Homicide determined (Specify)										-	4					
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as fedical Certification: To Be Completed by Physician				lan: To the be r:On the basis and manner	of examin												
	2	9b. Signature and title of ce	tifier	and mariner	Stuteu.			290	c. License	number			290	I. Date signe	d (Mor	th, Day, Year)	
		D-M)	_	_					O.C.M	l.E.			De	ecember :	23, 20	10	
	3	0. Name and address of per	son who														_
		Donna M. Vincenti,		Assistant			r 111	Penn	Street, I	Baltimo	re, MD	21201					_
State Registra	Ž	1. Date filed (Month, Day, Ye			Registrar's	- 6	Sa	Re	/								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death nth **Physician** /Medical 4c. County of Death Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner Augsburg Lutheran Home Woodlawn Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 17, 1912 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 ☑ F 98 Yrs. Maryland 216-07-9457 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Rosedale 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 1709 Summit Avenue USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 ⋈ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ 3 ₩ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Brass and Copper Company Factory Worker 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) William J. Taylor Christine Lucassen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3907 Hannon Court Mrs. Eileen Arnold - Niece Baltimore, MD 21236 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entomoment Gardens of Faith Cemetery 12-31-2010 Baltimore, Maryland Funeral Service Licerce 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 ind 23a. Part1. Enter the diverse, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail if e. List only one cause on such line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □Yes 2 No Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐ Yes 2/AN0 Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who complete

State Registrar

(Month, Day, Year)

2011

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DHMH 17 Rev 1/2001

			Please Type or Pri amend #9 Per FH State of M	i <b>nt in Black</b> G911 17( laryland / D	<b>k Indelible Ink.</b> 03/2011 JH epartment of Hea	Ensure Al alth and Mo	I Copies ental Hyg	Are Legible giene 2 ()   ()	41345
			State Registrar	(	Certificate of Dea	ath		Reg. No.	
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Shirley Holland Pin	kett			2. Date of Dea	7, <sup>D</sup> 2010 Year	3. Time of Death 11 56рм
	Examir	ier	4a. Facility Name (If not institution, give street and number) 719 Maiden Choice Ln #	¥634	4b. City, Town, or Loc Baltimo			4c. County of Dea	th
I	Funeral Director			ge (In yrs. last birtho	day) If Under 1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day ug • 8	9. Bir	thplace (State or Foreign
	and show	ē	Usual Residence of Decedent  10a. State 10b. County A	10c. City, Town o	or Location				10d. Inside City Limits
	e Maryli r 28a-f notifiec	Sirect		Balt	imore				1 X Yes 2 □ No
	with th s 23a o ust be	Funeral Director	10e. Street and Number 719 Maiden Choice Ln #	¥ 634	10f. Zip Code 21227	7		109. Citizen of What Co USA	ountry?
	or item		11. Marital Status  12. Was Decedent I Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 😿		13. Was Decedent of Hispa If Yes, specify Cuban, M	nic Origin? (Speci Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	e, etc.
0036	ours afte tural",	Completed by	3		1 ☐ Yes 2🏝 No S			Specify: B	.ack
215-	n 72 hc e. ian "na Medic	mple	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5	5.1) (C	Decedent's Usual Occupation Give kind of work done durin ife. DO NOT use retired)	n ng most of working	9	16b. Kind of Business Baltimore	e City
d 21	ed withi Hygiene other th	0	Elementary/Seconday (0-12) College (1-4 or 5 6 yrs 17. Father's Name (First, Middle, Last)	E	ducator	. Mother's Name (		Public Sc	hools
ylan	uld be file Mental narked c	10	James P. Holland			Alice W			
, Mar	nd 2 shou ealth and n 27 is n er traum		19a Informant's Name/Relationship (Type, Print) Stephen M. Pinkett, Sr/	Son   94	Mailing Address (Street and 1 02 Lencres	Number or Rural F t Rd. R	Route Number, Randal	City or Town, State, Zi stown, MI	o Code) ) 21133
/ / : らら PM Baltimore, Maryland 21215-0036	age 1 an ent of He ht: <b>If iten</b> y or oth		20a. Method of Disposition  1 ☐ Survival 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of C Garris	Disposition (Name of crematory or other place)	1/7/2		20c. Location - City or Owings Mi	
// : Baltii	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		22. Name and Address of 2700 Edmon	f FacilityBeve dson Av	erly D	Cromart	ie F/S 21223
			23a. Part Enter the disease, or complications that caused short, or heart failure. List only one cause on each line	d the death. Do not					Approximate
-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in depth)	static	gastrici	Cance	<u></u>		Onset and Death
127	Examiner	L	Due to (or as a	a consequence of):	7				
7	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter U. derlying Cause (Disease or injury	a consequence of):	:				
9	a 'a 'E	<del></del>	that initiated events c	a consequence of):	:				
© 09289	icate be physic s the bu	edica	d						
£ 68	th certifi tending or use a	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome 1 ☐ Live Birth	2 Fetal death	3 Dectopic pregnancy			23d. Date of de	
Lett.	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the bu	Physician/Medical	1  Yes 2 No 4 Pregnant a 9 Unknown	t time of death	5 Other (specify)			Month	Day Year
, P. 7	es that signed k	by P	Part II. Other significant conditions contributing to death b	out not resulting in t	the underlying cause given in	n Part I.	23e. Did tot	bacco use contribute to es 2   No 3 □ P	the cause of death?
and	w requir s been s s should	Completed					24a. Was a	n 24b. Were au	topsy findings available
and Recor	:The lay cate has	Com					autops perform 1  Yes	med? death?	completion of cause of
te (	/siclan: s certifi	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatio	ent 2 ER/Outp	Cabasi	of Death (Check o		ence 6 Other (Spec	
Jou	ling Phy n. After thi uneral c	ate: T	27. Manner of Death  1 Natural 5 Pending (Month, Day		ne of 28c. Injury at work?	28		ow injury occurred	<u>ny)</u>
ision	Attend er death ector: / by the f	Certificate:			M 1 ☐ Yes n, street, factory, office	2 🗆 No		reet and Number or Ru	ral Route Number,
Division of N	pital or ours afte eral Dir filled in	cal Ce	building, etc		- Al	10	City or Town		
S	the Hos in 24 h the Fun	Medical	29a. Certifier (Check only one)  1	xamination and/or in	nvestigation, in my opinion, de	eath occurred at th	ne time, date an	d place, and due to the	cause(s) and manner stated.
	North North		29b. Signature and title of certifier		29c. License nur		2	9d. Date signed (Monti	
1			30. Name and address of person who completed cause of de	eath (Item 23a) (Ty	pe, Print) A	x 24		12-29-20	10
170	Stat		31. Date filed (Month, Day, Year)	on Cata	m Ave SA	ctimal	Len	ND 517	29
	Registra	<b>~</b>	JAN 0 3 2011 Januar		artel				
A DH	MH 17 Rev 7/20	09							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 41346 State of Maryland / Department of Health and Mental Hygiene 4 U | U For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Wesley Raymond Paine December 2010 5:45pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Carrol1 Westminster If Under 1 Year I If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 23, 1918 Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral 1 🕅 M 2 🗆 F Months Days Hours Yrs Director 92 214-16-8134 MD Usual Residence of Decedent 23a or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 No MD Carrol1 Finksburg 10e. Street and Number 10g, Citizen of What Country? 3240 Old Westminster Pike USA 21048 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married X Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed WWII White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Batimore County Elementary/Seconday (0-12) College (1-4 or 5+) 5 Groundskeeper Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frank W. Paine Katherine Grover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Paine 21048 <u>3240 Old Westminster Pike.</u> Finkshurg MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 DRemoval from State 4 Donation 5 Other (Specify) Carroll Cremations 12/30/10 Hampstead, MD 21. Signature of Funeral Service 22. Name and Address of Facility 11824 Reisterstown Road ) W. OSTERLING Eline Funeral Home Reisterstown, MD 23a. Part I. Enter the diseasthern should be heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or us a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a co equence of): Hospital or Attending Physician: The law requires that the death certificate be executed MON that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy 2 LNo 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ျ 1 Tes 2 3 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nersing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No M Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined e Funeral E Medical 29a. Certifier 🕽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur

State
/ Registrar

DHMH 17 Rev 7/2009

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Malcoly drive West minsky NO 2(157)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kaneur

. Registrar's Signature

13.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:35 AM M 12 2010 Walter Joseph Polek, Sr Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Young At Heart Joppa Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 1 🕅 M 2 🗆 F Min. Hours **Director** Maryland 89 219-14-1918 Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 115 Shell Cove Court 21085 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced White Completed Year or Dates. WW II 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Imperial Marine Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John F. Polek Ida Warvasw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Virginia A. Leidiq</u> 115 Shell cove Court - Joppa. 21085 (daughter Maryland 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Pk.:01/03/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) led by the attending physician and detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown signed by to ld be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably has been sign e 2 should b Completed 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No Hospital 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 ☐ Yes 2 ☐ No. Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practigner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature and DØB/6389 of person who completed cause of death (Item 23a) (Type, Print) o completed cause of death (Item 23a) (Type, Print) VALARAO, H.O., 1716 HKRFORD RL SU. 105 FKLLSTON HD 4047 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Z U + U Certificate of Death 2, Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Howard Columbia Howard County General Hospital Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days July 5, 1924 Hours Min 1 🛛 M 2 🗆 F Months P8Tand 188-34-9516 86 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10a. State the Medical Examiner must be notified at Director 1 Yes 2 X No Columbia Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or Canadian Completed by Funeral 21044 4953 Reed Brook Lane items ? and 2 should be filed within 72 hours after death 1 Health and Mental Hygiene. Item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Linguistics Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Franizka Popek ည Alphonse Pietrzyk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Columbia, Maryland 21044 4953 Reed Brook Lane (Wife) Tina Pietrzyk 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12-29-2010 Clarksville, MD Columbia Memorial Pk injury 21. Signature of Funeral Service Licensee Witzke Funeral Homes, 5555 Twin Knolls Road Incolumbia, MD 21045 any 23a. Part 1. Eyfer the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, pheart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 1 Tes 2 **N**o 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pendina 1 Yes 2 No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 31. 2010 December 10:40 A M Picek Joseph Emanuel 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Baltimore Charlestown Nursing Center Catonsville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Months 1**x** x 1 2 □ F 05-29-1926 Maryland 220-20-6030 84 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 24 No Catonsville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21228 715 Maiden Choice Lane, PV 421 12. Was Decedent Ever in U.S. Armed Forces? 1★ X/es 2 □ No If Yes, Give Year or Dates: WW2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2XXMarried 1 ☐ Yes 2X ☐ No Specify Specify. 3 Widowed 4 Divorced White 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Principal Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara TeSar Anthony Picek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 715 Maiden Choice Ln, PV 421, Catonsville, MD 21228 Rosemary Picek - wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State 01-05-2011 Elkridge, Maryland Meadowridge Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityGary L. Kaufman Funeral Home at 21. Sign up of Fundal Service Licens MMP., Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Physician /Medical Examiner

Department of Health ar Important: If item 27 is any injury or other trau once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

items 23a or 28a-f show Examiner must be notified at

P.

and Mental Hygi

Director

Funeral

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Completed

Be

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MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition	a. Jementia	Onset and Death
resulting in death)	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate	b	
Cause (Disease or injury that initiated events resulting in death) Last	c	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ ∪nknown	23c. If yes, outcome of pregnancy 1  □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4 Unknown
		24a. Was an autopsy performed?  1 Yes 2 10 1 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
25. Was case referred to medical	26. Place of Dea	ath (Check only one)
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing F	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work?  M 1 Yes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 ☐ Certifying	Physician: To the best of my knowledge, death occurred at the time, date and place	and due to the cause(s) and manner as stated

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Amend Items 27,28a-i per me, g911,01/13/2011dhb

Certificate of Death

Reg. No. For State 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER Day 17 2 Year 10 1757 PM Physician/ ANISLAW Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CONTO BALTIMORE 5. Social Security Number UNK 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth July 17, 1942 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Months Days Hours P8Tand Director 68 Yrs Usual Residence of Decedent unk 28a-f shov unk must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director  $\operatorname{unk}_{1\;\square\;\mathsf{Yes}\;2\;\square\;\mathsf{No}}$ MD 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? unk unk unk 23a Funeral items filed with all Hygiene.
ad other than "natural", or items
ad other than "advalcal Examiner my 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education unk 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) laborer Be 18. Mother's Name (First, Middle, Maiden Surname)
Kazimera Kossakowski 17. Father's Name (First, Middle, Last) and Mental F ည Boonislaw Ptkas and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1927 Walnut Avenue Baltimore, MD 21222 Diane Wisniewski/sister permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 6 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 □ Donation 5 ☒ Other (Specify) in state Ronald S Wade State and Address Board 655 W. Baltimore Street Director w 21201 Baltimore, MD 23a. Part Nenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition 1 Coup ARD10 PULMONARY Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner SYSTEM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the burial-transit resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical law requires that the death certificate be 68760 AFFROYED BY MEDICAL BEAR IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnt 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying couse given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician, The 25. Was case referred to medical examiner?

1 ✓ Yes 2 ☐ No Division of Vital Be 26. Place of Death (Check only one) Hospital: 욘 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred
Lit Cigar ignited clothing. Certificate: work? 1 Tyes 2 X No 1 Natural 2 Accident injury Pendina 12/15/2010 1:41 Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2600 Block Boston Street, Balto., MD 28e. Place of Injury - At home farm, street factory, office building, etc. (Specify) Sidewalk outside determined grocery store Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the within 2 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 ASUKU EASTERN 32. Registrar's Signature State 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene U

			for State Registrar		State of Ma	ııyıanu	•	tificate of L		лиенан пу	Reg. No.		
	Physici	an	1 Decedent's Name	(First, Middle Las	<u>t)</u>		P	0/10/1	/	2. Date of De Month	Day	Year	3. Time of Death
	/Medic	cal	4a. Facility Name (If	not institution, give	street and number)		15	4b. City, Town, or	Location of Dea	Decen		County of Deat	0 0 7 - 7
	Examin	ier	The Johns					Baltimore	City				
	Funeral Director		5. Social Security N 246-96-44	409 1	ex 7. Age	6 (In yrs. lasi 54	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		ay, Year)	Co	thplace (State or Foreign untry) Ch Carolina
	land low		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Loc	cation					10d. Inside City Limits
	e Mary ta-f sh ffied a	ctor	MD	Howard		E	llicot	tt City					1 ☐ Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Nun 5135 She	<sup>nber</sup> ppard Lai	ne			10f. Zip-Code 210	)42		10g. Citiz	zen of What Co USA	untry?
	er dea items ier πυ	nue	11. Marital Status	and O Marriand	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	-	14. Race - Ame Black, White	
USP	urs aft al", or xamin	þ	1 ☐ Never Marrie	ed 2 □ Married 4 🎇 Divorced	1 X Yes 2 ☐ N If Yes, Give Year or Dates:	NO	1	☐ Yes 21 No	Specify:			Specify: b1	ack
3-003p	72 ho 'natura dical E	Completed	(Spec	15. Decedent's Ed			(Give I	lent's Usual Occup	during most of v	vorking	16b. Ki	ind of Business	/Industry
7	within ene. than the he	dmo	Elementary/Seco	ndary (0-12)	College (1-4 or 5	+)	mana)	00 NOT use retired Per	1)		tri	ucking	company
פר	e filed Il Hygi other ent, tl	Be C	17. Father's Name (	First, Middle, Last)			marra	unk	18. Mother's N	Name (First, Middle			Company
yiand	ould by Menta arked aric ev	P								asant McR			
Mar	d 2 sho		19a. Informant's Na			- 7		,		Rural Route Numl			Zip Code)
	f Healt f Healt item 2		20a. Method of Disp			20b. Plac	ce of Dispo	sition (Name of	i	Austell, Date		ocation - City or	Town, State
Ē	Pages nent o int: If i				Removal from State  in state		петегу, степ	natory or other plac	(e)				
Бащтог	permit. Departr Importa any Inju		21. Signaturur	neral Servic Lich	Wade, Dire	ctor		tareanA4939 altimore	•	ard 655 W 1201	. Ва	ltimore	Street
			23a. Part 1. Enter to	e disease, or comp	olications that caused one cause on each line	the death.					arrest,		Approximate Interval Between
Ton.	Physician	é Y	Immediate Cause (F	Final	a. Meta:			una ca	ncer			1	Onset and Death
1	/Medical Examiner		resulting in death)		Due to (or as			,	7.130.30.1				
		Jer	Sequentially list con if any, leading to im	iditions, mediate	b Due to (or as a	a consequer	nce of):						
	uted d ansit	Examiner	Cause. Enter Under Cause (Disease or i that initiated events	njury	C								
ي	ificate be executed physician and as the burial-transit	a E	resulting in death) L	ast	Due to (or as a	a consequer	nce of):						
98/90,	icate b physic s the t	ledical			.d								
J. DOX O	ie death cert the attending thed for use	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal d	eath 3	Ectopic pregnanc Other (specify)	у		:	23d. Date of de Month	livery Day Year
cords, F.	uires that tl signed by Id be detar	by	Part II. Other signif	cant conditions	ontributing to death b	ut not result	ing in the u	nderlying cause gi	iven in Part I.	23e. Did			o the cause of death? robably 4 \( \square\) Unknown
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director; After this certificate has been signed by completely filled in by the funeral director, page 2 should be detacted.	completed								24a. Was auto perfe 1 \( \subsection Yes		prior to death?	utopsy findings available completion of cause of
	cian: ertifica ector, p	Be C	25. Was case referre		Hospital:			Oth	or:	Death (Check only o			
5	Physic this or ral dir	는 일	1 Tes 2 1		28a. Date of Injur		R/Outpatient 8b. Time of	28c. Injur	4 🗆 Nursing	Home 5 ☐ Resi 28d. Describe			cify)
5	ading tth. : After e fune	ation	1 Natural 2 Accident	5 Pending investigation	(Month, Day	Year)	Injury	Worl			_		
22	al or Attending Physician: safter death. I Director: After this certifice id in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of inju building, etc		e, farm, stre	eet, factory, office		28f. Location City or To			dural Route Number,
	To the Hospital within 24 hours To the Funeral I	Medical (			ysician: To the best on the basis of and manner sta	examination							
	Vithir cong	Me	29b. Signature and	title of certifier	nah			290 license	e number	V	29d. Dat	te signed (Mont	h, Day, Year)
			P 1/1	ina les	, mD		,	174	25-6		Dec	emizer	17,2010
			Ni	tya Raj	,				60	0 North W	olfe S	t, Baltim	ore, MD, 21287
	Sta Registr		31. Date filed (Monta	032011	32. Registra	S Signature	par						

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Jennifer Porterfield State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Month Day December 29, 2010 Medical Examiner 1434 hrs Jenniter 4a. Facility Name (if not institution, give 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Center Randaallstown **Baltimore County** 5. Social Security Number If Under 1 Year If Under 24Hrs. 9. Birthplace (State or Age (In yrs. last birthday) Date of Birth (MM/DD/YYYY) **Funeral** Min Months Days Hours Director 1 M 2 **V** F Country' higan Usual Residence of Decedent ny 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No items 23a or 28a-f showust be notified at once, 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygene.

ant: If item 27 is marked tuther than "natural", ur items 23a or 28a-f she matthe reasons the property of the Medical Examiner must be notified at once, Director 10f. Zip Code 10g, Citizen of What Country Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married Yes Blac 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Be hereso 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 900 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Sign turn of Funeral Sa vice 08 Kennedy, St. ON Funeral sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, **Physician** Between Onset and e. List only one cause on each line /Medical Death a. Cardiac Arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Dilated Cardiomyopathy Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed cal UNPENDED AMENDED attending physician or use as the burial Physician/Med Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 Yes 2 No 3 Probably 4 ✔ Unknown Hypertension, Lupus, End Stage Renal Disease Completed After this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? page ✓ Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Other<sub>4</sub> Hospital: 1 Inpatient Nursing Home 5 Residence 6 2 FR/Outpatient 3 DOA Other 1 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No 5 | Pending death. the 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. S within 2 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 30, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

**ORIGINAL** 

DHMH 17 Rev 1/2001 OCMF 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Melvin Quasney 11:20 PM December Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Severna Park Genesis Eldercare Nursing Home 8. Date of Birth (Month, Day, Year) 07/08/1926 Social Security Number 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours 84 218 18 5975 Maryland Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State 10d, Inside City Limits Director Baltimore 1 Yes 2 X No Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21225 4214 - 4th Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 XWidowed 4 ☐ Divorced White WW II Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16h. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Retired - Builder Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည (not available) Quasney (not available) Lulie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bishopville, Maryland 21813 11904 Peyton Court Linda Quasney / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Glen Burnie, Maryland 12/30/2010 4 Donation 5 Other (Specify) Haven Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, Baltimore, Maryland 21225 4001 Ritchie Highway Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stenosis AOTHIC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Physician/Medical Examine Due to (or as a consequence of) sician and burial-transit or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year as been signed by the 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNO 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗙 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 \( \subseteq \text{Yes} \) 2 No Accident Suicide Investigation after death the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined the Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) D39 lelec December 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ltimore. Day, 31. Date filed (Month 32. Registrar Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death REDDIE Day Month Year **Physician** OUIS 30PM 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Battimore Villa NUISING Catonsville yrs. last birthday) Yrs. If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Min. 1 □ M 2 12 1 Months West Indies Jamaica lay Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a, State 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Eventine must be notified at 1 Yes 2 No Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Mountwood Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Blac Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Nurses Alde GEMC Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed withi and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Heatth and Ments Important: If item 27 is marked any injury or other traumatic ex Perturdo Brown -njece Mountwork di 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State butus Mem. to rbuttus 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Appr mate Inte al Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) **Medical** Due to (or as a consequence of): Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events ne Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performe certificate 1 □Yes 2 ☑No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this : After thi 28b. Time of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) URA MD M) 1009 derick 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 12 2010 Isabel M. Rexroth 10:11 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Heritage Harbour Nursing Home Annapolis 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g, Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Davs Hours Min 1 M 2 X Month 8 1918 Pennsylvania 90 Director 188-03-7953 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Maryland Anne Arundel Annapolis 10f, Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral U.S.A. 21401 2650 Compass Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Rusiness Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Kathryn Philips Peter Mathews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4616 Willow Grove Drive Ellicott City, MD 21042 Kathy Jacobs (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Crestlawn Memorial Pk 12-15-2010 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc 5555 Twin Knolls Road Columbia, MD 21045 21. Signature of Feneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one Interval Between cause on each line Onset and Death Immediate Cause (Final Disease h sician/ disease or condition resulting in death) Izheimers urars Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami signed by the attending physician and it be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 24 hours after death.

Funeral Director: After this certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA ၉ Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 🔲 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

within 2 To the

only one 29b. Signature and itle of

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3169 Braverton St #201.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death L Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ DEC arkash 0623AM DIC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOWARD HOSPITZ LUMBIA 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 ፟፟፟ M 2 ☐ F 7. Age (In vrs. last birthday **Funeral** Months January 8, Country) India 83 **Director** 225-41-3254 Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f sho Ex-miner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2🌠 No Maryland Howard Columbia 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21044 10799 Hickory Ridge Place United States hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian Indian "natural", Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Diplomat Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 and 2 should be Raj Bai Chanana traumatic Amir Chand Raswant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Anil Raswant/Son 8853 Doves Fly Way, Laurel, Maryland 20723 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth January 2, cemetery, crematory or other place)
West Arundel
Crematory 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Odenton, Maryland 2011 permit. 22. Name and Address of Facility Donaldson Funeral Home & Crematory, 1411 Annapolis Road, Odenton, Maryl 21. Signature of Funeral-Service Licen MO1386 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ SEPTIC disease or condition resulting in death) SHOCK de Medical Due to (or as a consequence of) Examiner obstruction tastatic coventially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death ☐ Pregnant
☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performe page 2 Dilu vena 25. Was case refer to medical examiner? Division of Vital completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 No ၉ 1 Nnpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending 24 hours after death.
Funeral Director: A Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) the 29d. Date signed (Month, Day, Year) MD, FCCP 36845

State Registrar 7350 Ovra C 31. Date filed (Month, Day, Year)

JAN 03 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 DECEMBER ROSEMARY RUDNICK 8:10A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Yrs Director 83 206-18-6749 <u>Pennsylvania</u> Usual Residence of Deceden 28a-f shov 10b. Count 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director MD Frederick Frederick 1 Yes 2 X No ъ 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8911 Danville Terrace 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0. Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify. 3 ☒ Widowed 4 ☐ Divorced Completed White Year or Dates other than "natu ent, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Hydiene. Homemaker Own home Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ Vincent Caricchio Angelina Merola 1 and 2 should b f Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Caricchio - nephew 8911 Danville Terrace, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it 1 😾 Burial 2 🗆 Cremation 3 😾 Removal from State 4 🗋 Donation 5 🗆 Other (Specify) 5 1/4/2011 injury Mount Carmel Cem. Penn Hills, PA 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Urcense ., New Windsor, MD <u>21776</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Arrhythmia Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): and -transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) \_\_\_\_ for in the past 12 months? Month Year Day Pregnant at time of death 1 ☐ Yes ∠ ≠ 9 ☐ Unknown the be detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. l signed l 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d, Describe how injury occurred 1 🗹 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MOD 65183 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

JAN U 3 2011

Frederick, mo 2170

400

10-09928 Keith Rakes Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	St I-For State Registrar	ate of Marylar		irtment o <i>tificate o</i>		d Mental 1		2 0	10 41359	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)							2. Date of Death Month Day Pear December 24, 2010  3. Time 081		
	4a. Facility Name (if not institution, give street and number) 18701 Roxbury Road				4b. City, Town, or Hagerstown		4c. County of Washington			
Funeral Director				ge (In yrs. last birthday)    If Under 1 Year			Irs. 8. Date of Bir	9. Birthplace (State or Foreign Country) Maryland		
F S G S S S S S S S S S S S S S S S S S	Usual Residence of Decedent			Oc. City, Town or Location				10d. Inside City Limits		
	Maryland Wash		Hagerstown 10f. Zip Code			1	1 Yes 2 No			
	18701 Roxbury Road  11. Marital Status 1 Never Married 2 Married Armed Forces			If Yes, specify Cuban, Mexican,				•A • American Indian, Black, etc.		
ours after de	3 Widowed 4 Div	orced If Yes, Give Year or Dates: cify only highest grade	2 X No		Yes 2 X No	ion (Give kind o		Specify:	White ness/Industry	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Elementary/Secondary (0-12)		or 5+)	during m	ost of working life. painte	er			idential	
	17. Father's Name (First, Middle)  William Leona  19a. Informant's Name/Relations	ard Rakes	_	19b. Mailin		F	me (First, Middle, I Evelyn G. Ir Bural Route Num		State Zin Code\	
MD 2 shou h and h and the number ic	Bonnie Kalbflei			123 Teapot Ct.			cstown, M	• • •		
Baltimore, I bernit. Pages I and Department of Heali Important: If item injury or other tra	20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other S		n State C	erematory or ot ce Cree	k Cemete	ry 12	Date /29/2010	nr. Lin	ity or Town, State	
Baltir permit. 1 Departm Imports injury or	21 Signature of Funeral Service		Blen	22. 1	Name and Address	of Facility Ha	rtzler	Funeral I dsor, MD	Home	
/Medical	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. <b>Heroin</b> ,	Amitri	ptyline					Approximate Interval Between Onset and Death	
	Sequentially list conditions,  b									
E	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									
0,  be executed sician and ourial - transit										
ox 687 eath certific tatending p for use as th	IF FEMALE: (23b. Was decedent pregnant in the past 12 months?)  1 Yes 2 No 9 Uni	ne 1 Live birt	nt at time of dea	2 Fe	tal death 3 [	Ectopic preg	nancy	23d. Date of de Month	əlivery Day Year	
, P.O. I res that the signed by the detache	Part II. Other significant condit	ions contributing to d	leath but not re	esulting in the u	anderlying cause g	iven in Part I.			ute to the cause of death?  Probably 4  Unknown	
Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the d within 24 hours after death.  To the Funeral Directors. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached ledical Certification: To Be Completed by Phy							1 🗸 Yes	sy prid med? dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 No	
irector	25. Was case referred to medica examiner?	Heapital:	patient 2	ER/Outpatient		of Death (Chec		Residence 6	Other: Scene	
in of Viding Physics in After this e funeral di	27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work? 28d Describe how injury occurred									
Division o spital or Attending spital or Attending nearl Director: After filled in by the fune Certification:	2 Accident Invest 3 Suicide 6 X Coul 4 Homicide		<b>Opm</b>   Grant Property of the property of the		28f. Location (S	unknown  28f. Location (Street and Number or Rural Route Number, City or Town, State) 18701 Roxbury Rd.  Hagerstown, Md.				
Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the I	4 Homicide (Specify) Jail Cell Hagerstown, Md.  29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  A Homicide (Specify) Jail Cell Hagerstown, Md.  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
M M M	29b. Signature and title of certifier			29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year)  December 25, 2010		
	30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
State Registrar	31. Date filed (Month, Day, Year)		strar's Signatu							

**ORIGINAL** 

OCME

Olivia Grace Ridd	le	Please Type of State of	· Print in Bla of Maryland /						ible.	nin	11360		
		- For State Registrar	,	•	tificate of				g. No.	. 0 1 0	71000		
Physician	1/	Decedent's Name (First, Middle,Last)					7	Date of Death     Month		Year	3. Time of Death		
Medical Examine		Olivia Gr. 4a. Facility Name (if not institution, give		<u>ddle</u>	14	City Tourn	r Location of Death	Month December		nty of Death	1038 hrs		
January .		Carroll Hospital Center	street and number)		*	Westminst		1	Carro	-			
Funeral	4	5. Social Security Number 6. Sex	7. Age	e (In yrs. la:	st birthday)	If Under 1 Yes		s. 8. Date of Birth	(MM/DD/Y	YYY) 9. Birtl	nplace (State or		
Director		217-87-3073	и 2XF		Yrs.	Months Day			201	Foreign	n intry(),a		
	ŀ	Usual Residence of Decedent				<u>  8   18</u>	31	Apr. 9	201	<u>U I</u>	Maryland		
' any	ſ	10a. State 10b. County		10c. City, 7	Town or Location	n					10d. Inside City Limits		
Baltimore, MD 21215-0036  Baltimore, MD 21215-0036  Begarting to fleat a should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 23a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	ا ق	Maryland Carroll					1 X Yes 2 No						
	<u></u>	10e. Street and Number				10f. Zip Code	10		f What Coun	try?			
th the notification of Discourse		528 Daisy Drive 11. Marital Status 12. Was Decedent Ever in U.S			1 10 101	5 1 1 11			J.S.A.				
ath wi	Funeral	11. Marital Status 1 X Never Married 2 Married	Armed Forces?	_			spanic Origin? ( S n, Mexican, Puerto			Race - Americ Vhite, etc.	an Indian, Black,		
F. er de		3 Widowed 4 Divorced	1 Yes 2 Yes 2	X No	1	Yes 2X No	specify:		Spec	cify: B	lack		
ours at	g S	15. Decedent's Education (Specify only	or Dates: highest grade com	pleted)			ation (Give kind of		16b. Kind o	of Business/Ir			
72 hc	<u>e</u>	Elementary/Secondary (0-12) College (1-4 or 5+)			during mo	st of working life	e. DO NOT use ret	ired)					
within iner the Medi	Completed	0			ne	ever wo		N/A					
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica	္တိ  ရူ	17. Father's Name (First, Middle, Last)  William Riddle, Jr.						(First, Middle, Maiden Surname)					
212 ould be Mente mark ic even		19a. Informant's Name/Relationship (Typ		19b. Mailing	Address (Stre		ny Brooks Rural Route Number, City or Town, State, Zip Code)			Zip Code)			
MD d 2 sho lth and n 27 is	-	Brittany Brooks-R	iddle/mot	her	528 I	aisy Dr	Tan	eytown,	MD 21	787			
re, I	1	20a. Method of Disposition	-	20b. P	lace of Dispositematory or other	ion (Name of ce		Date		ion - City or <sup>-</sup>	Town, State		
MOFE Pages 1 tent of 1 tut: If i	1	1 X Burial 2 Cremation 3 Donation 5 Other Specify:	Removal from Sta	i.e	. Joy (		7   12/	31/2010	Unic	ntown,	, MD		
Baltimore, permit. Pages I at Department of He. Important: If ite injury or other tr	1	2 Inphature of Funeral Service License	2./	22. Na	me and Addres	s of Facility Har	tzler Funeral Home						
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Physician /Medical Fxaminer		23a. Part I. Enter the disease, or complice failure. List only one cause on each	n line.						st, shock, o	r heart	Approximate Interval Between Onset and		
	-		Sudden un ue to (or as a conse			atn in	iniancy	(ZODI)			Death		
	-	Sequentially list conditions, b	de to (or as a conse	is a consequence or):									
led nsit		if any, leading to immediate D cause. Enter Underlying Cause	:										
		(Disease or injury that initiated C.	quence of)	f):									
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ੂ ਜ਼ਿਲ੍ਹ	g   g	UNPENDED	AMENDED 23a	,27,2	8a-f,pe	r ME gg	13 3/3/1	1 TT					
ox 68760, eath certificate be extacted in physician for use as the burial.		IF FEMALE: 3b. Was decedent pregnant in the	e of pregna	gnancy				23d. Date of delivery  Month Day					
x 68 h certi tendin use as	흥	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnar 4 Pregnant at time of death 5 Other (Specify)						aricy	l Mon	ui D	ay Year		
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Orc law re has be 2 sho	Completed							autopsy prior to completion of performed? death?					
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ion ttendin leath. tor: A the fur	<u> </u>	Pending Fd 12/27/10 F				Fd9:48 am 1 1 Yes 2 X No				unk			
ViSi or Att fler de in by:	≝	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home					28f. Location (Street and Number or Rural Route Number, City or Town State) 228 Daisy Di						
Divis pital or At ours after d neral Direct filled in by	Certification:	4 Homicide determined (Specify) residence Taneytown, MD											
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)											
To tl withi To th	2 L	2   -	ind manner stated.	A A				I are time, date a					
		29b. Signature and title of certifier  29c. License number  O.C.M.E.							29d. Date signed (Month, Day, Year)  December 28, 2010				
	30) Neither and address of person who completed cause of death (Item 23a)												
	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
Stat		31. Date filed (Month, Day, Year)	32. Registrar	's Signatur	e de la la								
Registra	ar	JAN 0 3 2011	Chum	10. P	back					OOME			
DI 18 41 1 4 7 D 4 10 0 0										spring EPT feet			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7:45 AM<sub>M</sub> Russell Reineck, Sr. Physician/ William Month 2010 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Finksburg 2405 Alpine Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov • 9 1925 **Funeral** Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Min. 1 1 M 2 - F 85 Country) 213-20-7025 Director MD Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Finksburg Carroll MD 1 🗆 Yes 2 🏝 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21048 Funeral 2405 Alpine Court death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes 2 No WWII Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Specify: white Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) law attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)* Estelle Lydia Henriques William Henry Reineck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2405 Alpine Ct., Finksburg, MD 21048 Dorothy E. Reineck (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Nourial 2 Cremation 3 Removal from State cemetery, crematory or other place) Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) ¦1−3−11 Lake View Memorial 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licenses Pargrapaigh of the P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Ears resulting in death) Medical Due to (or as a consequence of) caminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of sician and burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔂 Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No fter death. 2 Accident Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 10051924 21102 30. Name and address. of person who completed cause of death (Item 23a) (Type, Print) Manchester Rd Man 297 Herbe

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G911 1/07 2011 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year -25 P RANE OBISON 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 210213 ELLIWIT CITY WIGT CII MD Howat 4 KEHAB Howard 5. Social Security Number If Under 1 Year Age (In vrs. last birthday, If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F 91 Months Days Hours Min. (Month Day, Year) eb 9 1919 Director 219-16-7980 MD Feb Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits Woodstock MD Howard 1 Tes 2 No 10f. Zip Gode 21163 10e. Street and Number 10g. Citizen of What Country? 10354 Route 99 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Oriole Cafe hostess Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louisa Clara Gude Rudolph Herman Affeldt 19 Carrol y Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline Kulp (daughter) 10226 Green Clover Dr., Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit, Page 1 a
Department of I
Important; If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place.
Lake View Memorial Sykesville, MD 1-4-11 21. Signature of Funeral Sorvice License 22. Name and Address of Facility Haight Funeral Home & Chapel Box 195 Sykesville, MD 21784 .0. 23a. Part 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PNAC Immediate Cause (Final UTE ₹hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown signed by the 1 L Yes 2 | 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown filled in by the funeral director, page 2 should certificate has been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No Yes 25. Was case referred to medica examiner? Be 26. Place of Death Check only one Hospital 2 4 No မ 1 🔲 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I Director: After this Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending Accident 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Lecritiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) alle elle 5 5m1774 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DFC  $30^{\text{Day}}$ 2010 Ella May Ruby 10:55a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Sykesville Fairhaven 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last hirthday) 8. Date of Birth Funeral Days Min NOV 25, 1920 1 M 2 TyF Mary land 90 Director 579-14-7309 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director r 28a-f s notified 1 🗆 Yes 2 🖁 No Sykesville Carrol1 Marvland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be 23a 21784 USA 7300 Third Avenue C118 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Completed by and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Hitem 27 is marked of other traumatic even ပ Annie Mary Robinson George Roy Aist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 Brangles Court Marriottsville, MD 21104 Barbara Jean Miles/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 1/4/2011 Sykesville, MD 4 Donation 5 Other (Specify) Lake View Memorial Park 21. Signature of Funeral Service License 22. Name and Address of Facility Home & Chapel, P.A. P.O. Box 195 Sykesville, MD 21784 Jama.mc (410-795-1400) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ mphoma disease or condition Medical resulting in death) Due to (or as a crinsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impury that initiated events Examine Due to (or as a consequence of): physician and the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
g Unknown for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed I ral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 - Residence 6 - Other (Specify) 2 No ပ္ 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature ag 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eldersburg MD 645 Liberti MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ammend item 20b per fh g911 1-7-11 vt State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 24, 2010 Physician/ 3:45 а м Harold Rapp, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Lutherville Tallwood 8519 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) Funeral Months Days Hours Penrisylvania 1 ₹ M 2 □ F 89 177-14-9287 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2 X No Maryland Lutherville Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21093 8519 Tallwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian. 11. Marital Status Was Decedent Ever in U.S Armed Forces? 1 ∑ Yes 2 ☐ No If Yes, Give Year or Dates. WW II Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Coast Guard Officer - Coast Guard Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Marion Brown Rapp, Sr. Harold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8519 Tallwood Road Lutherville, Md. 21093 Anna E. Rapp / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dateunk 1 XBurial 2 Cremation 3 Removal from State 1 - 20 - 11Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Va. 21. Signature of Funeral 2 rvice Licen 22. Name and Address of Facility 1050 York Rd. Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ To we disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🔄 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R125808 W. Krop 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anna Laws Villanuseus. N. Charles Stc 4105 S 31. Date filed (Month, Pay Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death DECEMBER, 29 Physician/ 9.50 AM Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** HOSP ITAL Ballimore AGNES Social Security Number If Under 24 Hrs Birthplace Country) 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral If Under 1 □ M 2 🕱 F Months Director ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Himore MD 1 **Y** Yes 2 □ No 10e. Street and Nuproer 10q. Citizen of What Country? Funeral 21216 USA iedmont 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: Specify: Black and Mental Hygiene. is marked other than "natural", 3 Widowed 4 □ Divorced 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Banking other's Name (First, Middle, Ma Kostor Zora dSon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) ied mont Ave. Balto. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -10-11 21. Signature of Funeral Service Licensee Faciliareene funeral Services lto. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ INTRACEREBRAL HEMORRHAGIC a LARGE PPROXIMATELY disease or condition Medical resulting in death) Due to (or as a consequence of) STROKE 14 hours. **Examiner** Sequentially list conditions. Examine Due to (or sele consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 1 L Yes 2 D Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by WITH HYPERTENSIVE ESSENTIAL HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CARDIOVASCULAR DISEASE HYPOTHYROIDISM 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? SEVERE HYPOKALEMIA 2 🗌 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) the Hospital or Attending Physician examiner? 2 **N**0 1 Nonpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D0018362 (ama0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Md21229 Wilkens Ave. Ste 40. 3455. k. Dang M.D State Registrar

SMITH

CERISTINA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Serena Spence 24 2010 10p <sup>M</sup> Dec 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Baltimore Baltimore 7. Age (In yrs. last birthday) 31 Yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 216-17-8244 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birting Country) MD Days 1 M 2 X F July 27, Director 1979 Usual Residence of Decedent 10b. County N/A ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Baltimore 10d. Inside City Limits Director 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1109 Wicklow Road 21229 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Genesis Elementary/Seconday (0-12) College (1-4 or 5+) Medicine Aide Eldercare 12th 1vr Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Darryl Spence Mary Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 Cooks Ln. Baltimore, Md. 21229 Mary Spence/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State New Cathedral Ce 1/3/2011 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beverly D. Cromart 2700 Edmondson Ave. Balto., MD 21. Sign ture of Funeral Service License Cromartie F/s 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sbock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or): Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death.

Funeral Director. After this certificate has been signed by the attending physician and ated filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy pertormed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 NNO မ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) No 3 Pure 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 1/Certifying Physician: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nume Practioner: To the best of my knowledge, decit occurred at the time date and place 29b. Signa ature and title of certifie December 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 6701 TOWSON MI N 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month & Sim 2 101 Dam Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death Baltimore Joseph Richey Hospice n/a Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) Korea 1 X M 2 □ F Months Hours November 11 81 Director 214-13-0989 1929 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland Anne Arundel Severn 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7910 W. B and A Rd. 21144 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. . 0. Black, White, etc. þ 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural". Completed 3 Widowed 4 Divorced Asian Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) carpentry/electric carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ki Hong Sim unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jong Pae Sim/son 7910 W. B and A Rd. Severn, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State any injury once. 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Gard Jan. 2,2011 Timonium, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
John O. Mitchell IV, Funeral Services of Dulaney Valley
200 F. Padonia Rd. Timonium, MD 21093
P. A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for es a consequence offi attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No to the runeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 🗌 Yes 2 No 3 🗆 Probably 4 🗆 Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🖼 မ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5  $\square$  Pending injury Division Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 30, 2010 12:20 PM Frank Schirmer, Jr. Anthony Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Middle River 508 Grovethorn Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Date of bill. (Month, Day, 1) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 937 Maryland 73 Yrs **Director** 216-34-3668 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland the Medical Examiner must be notified at by Funeral Director 1 Yes 2 No Baltimore Essex Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a 239 Orville Road 21221 U.S.A. or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 XYes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 21215-0036 Specify. White 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Korea Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Balto. Gas & Electric al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **BGE** Test Person of Health and Mental Hygie If item 27 is marked other or other traumatic event, the To Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve Anna Marie Westfield Anthony Frank Schirmer, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 239 Orville Road, Baltimore, Maryland 21221 Verda Schirmer (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Balto. Nat'l. Cem. 01/03/2011 Catonsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facilityski Funeral Home, 21. Signature of Funeral Service Licensee P.A. Maryland 21221 Old Eastern Avenue, Essex, Part 1. Fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm ate Cause (Final disasse or condition Physician/ Bowel Obstruction Medical re ulting in death) **Examiner** Pancreatic Cancer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3XXProbably 4 ☐ Unknown Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No Yes 2 X No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Baughter's Hospital: Other: 2 K MIn 1 Tyes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Spec 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1XXNatural 5 Pending s after deseral Director; A 1 Tes 2 🗌 No Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29b. Signature and title of certifier 00061658 deatt (Item 23a) (Type, Print) 30. Name and address of person who completed cause GOON. Wolfe St. Osler GWG 62. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Viola Marie Stone 30, 2016 3:00 AMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 119 Encore Court Centreville Oueen Annes If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Davs Hours Min 05/07/1930 Mary Land Director 80 214-24-8762 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Queen Anne Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 119 Encore Court 21617 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian ģ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify: Completed 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Bus Driver Aid Balto. Co. School i. Page 1 and 2 should be filed witnerit of Health and Mental Hygintant: If item 27 is marked other jury or other traumatic event, It Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ್ತ John Fruend Viola Chester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kearfott Britton Stone (Husband) 119 Encore Court Centreville, Maryland 21617 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 01/03/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, 21221 Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YOCARDIAL Physician NFARCTIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ysician and e burial-transit that the death certificate be executed PE that initiated events Due to (or as a consequence of): resulting in death) Last physician at the burial EROLEMI Physician/Medical Box 68760 attending plant for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death the 9 Hnknown 9 Unknown P.O. | ed by t detach s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EBROUAS (ULAR Records, 2 

No 3 □ Probably 4 □ Unknown 1 Tes YPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an aw Jas ge 2 autopsy performed? Hospital or Attending Physician: The 1 Yes 2 No Yes 2 No ď Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 28b. Time of injury 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 629 Railroad Avenue, Centreville, Md. 21617 Dr. Eric Ciganek, 31. Date filed (Month, Day, Year)
JAN 03 2011

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Maryla	nd / Depa	rtment tificate			and M	lental Hy		-201		370	
	_		Registrar  1. Decedent's Name (First, Middle)	e, Last)		Cer	uncate	OI D	eaur		2. Date of De	Reg. No	0 1	3. Time o	f Death	
	Physicia Medic		MARY ALICE SHEE				December 24 2010 5:20									
_ 1	Examin		4a. Facility Name (if not institution	, give street and nur	mber)	4b. City, Town, or Location of Dea						4c. County of Death				
لممي			BALTIMORE WASH				GLEN			044 <i>i</i> I		ANNE ARUNDEL				
	Funeral Director		5. Social Security Number <b>215.22.3731</b>	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. <b>84</b>	last birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da OCT 7,	th 1926	9.1	Birthplace (State of Country)	or Forei <b>g</b> n	
	*		Usual Residence of Decedent		<u> </u>											
	yland -f show ed at.	ctor	10a. State 10b. County		10c. C	City, Town or Loc	ation							10d. Inside C		
	r 28a notifi	Dire	MD ANNE A  10e. Street and Number	RUNDEL	LIN	THICUM	10f. Zip C	ode.				1 ☐ Yes 2 <b>XX</b> No				
	vith th	Funeral Director	6317 SOUTH OR	THARD RD				1090				10g. Citizen of What Country?  USA				
	eath v	Fune	11. Marital Status	12. Was Dec	edent Ever in L	J.S. 13. V	Vas Deceden	nt of His	panic Ori	gin? (Spe	cify Yes or No-	Т	14. Race - Ai	merican Indian,		
စ္က	fter d ", or i	by	1 Never Married 2 XX	ried Armed Fo	2 <b>XX</b> No		Yes, specify				rican, etc.)		Black, W			
3	ours a Itural'	3 Wildowed 4 Divorced Year or Dates.  15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  12  15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)  SECRETARY  SECRETARY											Specify:	WHITE		
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717	within giene. er tha , the I		Elementary/Seconday (0-12)	College (1	1-4 or 5+)		RETARY	,					LEGAL			
Maryland 21215-0036	be filed within 72 hours after death with the Maryland and Hygiene. As the death thin "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho cevent, the Medical Examiner must be notified at.	To Be	17. Father's Name (First, Middle,								(First, Middle,	Maiden	Surname)			
<u>₹</u>	0 5 5 0		HARRY BURKHARD			1				ERA						
Z Z	12 should lith and Me 27 is mar r traumati		19a. Informant's Name/Relations  CHARLES WARD SI		HUSBAND		•				Route Numbe			Zip Code)		
	ye 1 and t of Heal If item 2 or other		20a. Method of Disposition		20b.	Place of Dispo	sition (Name	of			ate			or Town, State		
Ê	Page nent o ant; If ury or		1 ☐ Burial <b>XX</b> Cremation 4 ☐ Donation 5 ☐ Other (		n State BA	cemetery, cren YVIEW CRI				12.28	.2010	BALT	IMORE, N	4D		
Baltimore,	permit. Page Department of Important; If any injury or once.		21. Si / Charles Servio	renjee	2		NAME TUNE	Address	HOME!	YP.A.						
n	g Q = # 9		CRECORY FIN	<del>-</del>	M01148	42	6 CRAIN	N HWY	SW C	LEN B	JRNIE, M		61	1		
			shock, or heart failure. List	complications that ly one cause on ea		ath. Do not ente	60 0		0.2	cardiac o	r respiratory a	rest,		Approxima Interval Be Onset and	tween	
Р ,	nysician/ Medical	3 4	Immediate Cause (Final disease or condition resulting in death)  a. Due to ris a consequence of):										Death			
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3	requires mat the deam centificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical		d												
20	iding	M/C	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregr	nancy							23d. Date of	deliven		
Pox	eath c atter	iciai	in the past 12 months?  1  Yes 2 No	1 Live	Birth 2 🗌 Fe gnant at time o	etal death 3 📙	Ectopic pre Other (spec					T	Month		Year	
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5	s tnat gned   oe det	by F	Part II. Other significant conditi	ons contributing to o	death but not re	esulting in the u	nderlying cau	use give	n in Part	l.				to the cause of		
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ř	n: 1 ne ficate or, pag	e Co	25. Was case referred to medical					OS Dias	a of Doo	Ab (Chaole	1 🗆 Yes			Yes 2 □ No		
1 Ta	/sicial	To Be	examiner?	Hospital:	Innatient 2	ER/Outpatier		Tothor		th (Check	ne 5 🗆 Resi	dence 6	Other (So	peciful		
0	ig Pin ter thi neral (		27. Manner of Death	28a. Date		28b. Time of injury		i. Injury a work?	_		8d. Describe			,		
ם י	tendir leath. or; Af the fu	ifica	1 Natural 5 Pendi 2 Accident Invest 3 Suicide 6 Could	gation		,/	М		es 2 🗆	No						
DIVISION OT	or Att after d Direct in by	Certificate:	4 Homicide determ	ained 28e. Place	e of Injury - At I ing, etc. <i>(Speci</i>	nome, farm, stre ify)	et, factory, o	office		1	28f. Location ( City or To			Rural Route Num.	ber,	
ָ ב	to the postpial of Attending Priysician: The law requires that the beam within 24 hours after death.  Within 24 hours after death.  Completed filled in by the funeral director, page 2 should be detached for to complete the properties of the funeral director.			Physician: To the I											- 2	
	ne no in 24 t ne Fui pletec	Medical		Examiner: On the ba Nurse Practioner:											anner stated.	
	Vithi Com		29b. Signature and title of certifie	r			29c. L	icense r				29d. Da	te signed (Mo	onth, Day, Year)		
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			30. Name and address of person	who completed cau	se of death (Ite	em 23a) (Type, P	rint)		<u>0d</u>	Ro	21 (	len	2	21061	^	
	Stat	e.	31. Date filed (Month, Day, Year)	32.	egistrar's Sign	laturer /		wa.	<u>na</u>	KO	00 0	NON	רטטרו	VICE ON	1	
	Registra		JAN 0	3 2011	news	B. A.	arkel									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20bac Per FH G911 / 13/2011 In State of Maryland / Department of Health and Mental Hygiene Certificate of Death State
Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 30 Month 2107 M Physician/ sloanl Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner timore UMMC Battimore 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number 10-29-68 MD (Country) Hours Min. Days Months **Funeral** 42 217-88-5379 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examples. 10b. County 10a. State 1 Yes 2 ☐ No Director Baltimore N/AMD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21207 1210 Newfield Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1989 – 96 Year or Dates. 11. Marital Status Black, White, etc. African Specify American Completed by 1 Never Married 2 X Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Sawyer Holding Refrigerant Transition College (1-4 or 5+) Elementary/Seconday (0-12) 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Doris Sloane ٩ unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Blanche Sloane/Wife 1210 Newfield Road, Baltimore, MD 21207 2Badetton - CMD Town, State 20b. Chest of Passifion Center backy 1/17/2011 20a. Method of Disposition 1 XBunal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harip. Close F Sys PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Dreta Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner aneury NSE Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and ending physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Year Month Day in the past 12 months? Pregnant at time of death φ 1 Yes 2 No g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed I should be det 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b, Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy completed filled in by the funeral director, page 2: performed? 2 X N ☐ Yes 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner? Other: Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🔲 DOA 2 X No မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: injury 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Gertifying News Fractioner: On the basic of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 32 5 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addit 32. Registrar's Sign Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Thomas Smith Dec 9:15 P <sup>M</sup> 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BonSecours Hospital Baltimore Social Security Number 8. Date of Birth (Month, Pay, Year) 02-14-2 Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 87 Hours 1 X M 2 □ F 225-34-7345 Director Yrs. VA Usual Residence of Decedent 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified MD NA Baltimore XX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 McMechen Street Apt.#923 21217 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: American Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver 12th Grade B.W. Hovermill NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ella Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 Edith Smith-Wife McMechen Street Apt. #923 Baltimore. MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Garrison Forest 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01-05-11 Owings Mills, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lucensee Wylie Funeral Home P.A. 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or comple stions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) wini Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No signed by the atte Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Completed 1 Yes 2 No 3 Probably Wunknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Director; After this certificate 2 X No 1 Yes Yes the Hospital or Attending Physician: ' 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 Pending injury 1 🔲 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical 29a. Certifier Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d, Date signed (Month, Day, Year) 1)2644

Registrar
DHMH 17 Rev 7/2009

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31. Date filed (Month

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-09589 State of Maryland / Department of Health and Mental Hygiene John Benedict Sigwarth Certificate of Death Decedent's Name (First, Middle,Last) 2 Date of Death 3 Time of Death Physician/ Month 0950 hrs December 13, 2010 Medical Examiner John Benedict Sigwarth 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Howard 9215 Mellenbrook Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Months Days Hours Country) Director 12-20-1960 1 X M 2 F Iowa 49 4**84-**68-1055 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ij 10a. State 10b. County 1 Yes 2 X No "natural", or items 23a or 28a-f show | Examiner must he notified at once. Columbia MD Howard imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
\*\*ant: If item 27 is marked other than "natural", or items 23s or 28s-f sho Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21045 9215 Mellenbrook Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funera 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces' 1 Never Married 2 X Married Yes White f Yes, Give Year 1 Yes 2 X No specify Specify: 3 Widowed 4 Divorced <u>6</u> 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) event, the Medical N.A.S.A. Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eleanor Heiberger Be Celestine A. Sigwarth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 9215 Mellenbrook Road Columbia, Maryland 21045 (Wife) Nicola Fox 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12-21-2010 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Other Specify: 22 Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 21. Signature of Funeral Service Livens Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Retween Onset and failure. List only one cause on each line, Medica a. Hemopericardium Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): b. Ruptured Aortic Arch Aneurysm Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause c. Hypertensive Atherosclerotic Cardiovascular Disease (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and tran Physician/Medical UNPENDED AMENDED ending physician use as the burial Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Day Year Month past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown the signed by the 23e. Did tobacco use contribute to the cause of death? P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. á 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available After this certificate has been prior to completion of cause of autopsy . death? page 2: 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene DOA 2 ER/Outpatient 3 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 V Natural Division 1 Yes 2 No 5 Pending Director: filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after To the Funeral Dire 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E December 14, 2010 30. Name and address of person who completed cause of death (Item 23a) OCME 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Mary G. Ripple MD.

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day Year)

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Denny Charles Slaubaugh 11:45 A M 2010 December Medical 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Medical Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** octionth, Pay, 1 🔀 M 2 🗆 F Months Days Hours Min. Year 949 61 216-52**-**5843 Pennsylvania Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director Carroll County Hampstead must be notified Maryland 28a-f 1 X Yes 2 No 10f. Zip Code P 10e. Street and Number 10g. Citizen of What Country? 1516 North Main Street 21074 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Year or Dates and Mental Hygiene.

is marked other than "natur
aumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) truck driver overland transport Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Clifford Slaubaugh Virginia Haas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Pamela Simmons / friend 3226 Boone Drive Manchester, Maryland 21102 20b. Place of Disposition (Name of 20a. Method of Disposition Dec. 30, 20c. Location - City or Town, State cemetery, crematory or other place)
Carroll Cremation 1 ☐ Burial 2 🏿 Cremation 3 🗍 Removal from State Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service Licen 22. Name and Address of Facility Eline Funeral Home creet Hampstead, Maryland 21074 934 South Main Street M01072 um 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myrcardin Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ þ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached a I IInknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has be lirector, page 2 s autopsy performed? Yes 2 No 1 Tes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Gentifying invalidation to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Gentifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2010 pleted cause of death (Item 23a) (Type

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 14, 2010 December 11:57 PM Vincent Spencer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Howard Columbia Lorien Columbia If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 ☑ M 2 □ F 62 Aug 26, 1948 Director 231-66-1038 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f shov if than "natural", or items 23a or 28a-f sho Director ty⊡Yes 2 □ No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21216 USA 3313 Poplar Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. ģ Specify: black 3 Widowed 4 Divorced Completed un 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) factory worker is marked other 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau 6334 Cedar Lane Columbia, MD Lorien Columbia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5幫Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street cell Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. A oximate n erval Between nset and De Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to () as,a consequence of) **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed and-trar Due to (or as a consequence of) burial physician s the burial Box 68760 Physician/Medical attending nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No signed by the a Ö 9 Unknown 9 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an has page 2 s autopsy certificate 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation 1 Natural unknown death. 2 Accident 12/1989 1 ☐ Yes 2 🗷 No after death

Director: ,
d in by the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) within 24 hours aft To the Funeral Di completely filled in UNKNOWN nown Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 28, 11:25 P™ 2010 BENJAMIN SAPPERSTEIN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE BALTIMORE NORTH OAKS HEALTH CENTER 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🕅 M 2 🗆 F Days Hours Min 0672771919 MD 217-01-7882 91 Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any any injury or other traumate. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No BALTIMORE BALTIMORE MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 725 MT. WILSON LANE, #433 21208 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) ACCOUNTING TAX ATTORNEY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 SOPHIE SMELKENSON SIMON SAPPERSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 MT. WILSON LANE, BALTIMORE, MD REBA E. SAPPERSTEIN/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB CEMETERY 12/30/2010 FINKSBURG, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events ostake Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No signed by the aid be detached f g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Drakentricy/as 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣ ☐ Unknown ficate has been siç r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 No Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Post tifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title o 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature JAN 0 3 2011

DHMH 17 Rev 7/2009

Registrar

Amend 29c, per DVR g911 1/3/11 TT State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month Neth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. Gity, Town, or Location of Death 4c. County of Death Mea ICAL N/A 9. Birthplace (State or Foreign Country) Maryland If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M M 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Days Hours Min. 63 Yrs 217 46 4987 Director 06/09/1947 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natura" any injury or other traumatic events. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 828 Hammonds Lane 21225 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 x Yes 2 □ No If Yes, Give Year or Dates. 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Self employed Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Ralph Melvin Scarlett Hilda Marie Twigg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21225 828 Hammonds Lane Joyce Mullineaux 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 12/29/2010 Marriottsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failers. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Cardiomyopati disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has how sinned by the attending the continuation. attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE. 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Yes 2 No signed by the a g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown cate has been signated based by Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 🗋 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) **RES000** 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 NORTH GREENE STREET. 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Thomsen, Jr. Robert 2:48 P M 26 2010 Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Gilchrist Hospice Center Baltimore Co Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min Dec. 18,1972 Utah 38 Director 216-17-1134 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Dunda1k Baltimore 1 Ves 2 No MD 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must b 7818 Deboy Avenue United States 21222 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: 3 - Widowed 4 X Divorced Specify. White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry Mechanic 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frances M. Evans Robert L. Thomsen, Sr. 19a. Informant's Name/Relationship (Type, Print) Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7818 Deboy Ave. Dundalk, Maryland 21222 Mr. Robert L. Thomsen, Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Department of Important: If any injury or Baltimore, Maryland Gardens of Faith Cem. 12/30/2010 4 Donation 5 Dother (Specify) Signature of Fundral Zervice Lic Dida-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk. Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Cancer 0100 month Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician cian/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Physic Yes 2 No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform certificate Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specifi) 103 PL 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) hr 26 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mg

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Phy	sicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death		
	ledic	al	Irene Vance 4a. Facility Name (if not institution, give street and number)				December	Т.			
Exa	amin	er	5510 Harvest Scene Court		4b. City, Town, or Li			4c. County of De	vard		
Fun			5. Social Security Number 6. Sex 7. Age (In yr.	s. last birthday)  Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth March 2	9. B	irthplace (State or Foreign ountry) Texas		
			Usual Residence of Decedent					-,			
ıryland	ied at	ctor		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No		
he Ma or 28	e notii	P. P.	Maryland Howard  10e. Street and Number	COLUII	10f. Zip Code		11	0g. Citizen of What 0	1		
with t	nst b	Funeral Director	5510 Harvest Scene Court		21045	5		U.S.A			
death r item	iner m		11. Marital Status 12. Was Decedent Ever in Armed Forces?		Was Decedent of Hisp If Yes, specify Cuban,	oanic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh			
036 s after ral", o	Exam	g b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XXNo If Yes, Give 19 Year or Dates.		1 ☐ Yes 2 ☐ <b>X</b> No	Specify:		Specify:	Black		
<b>5-0</b> 2 hour "natu	dical	plete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupati kind of work done dur	ion ring most of worki	ina .	16b. Kind of Busines	s Industry		
ithin 7 ene.	he Me	Completed by	Elementary/Seconday (0-12) College (1-4 or 5+)	life. D	O NOT use retired)			Food S	ervice		
land 21215-0036  be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho	vent, t	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name					
Maryland 21215-0036 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show	atic e	٩	Foster Simmons			Annabe	11 Jones		<u> </u>		
Baltimore, Maryland 21215-0036  bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", o	er traun		19a. Informant's Name/Relationship (Type, Print)  Jeraldine Jackson (Daughter)		ng Address (Street and ? Flagflowe			City or Town, State, 2			
Page 1 an nent of He ant; If iten	v or oth		1 🖫 Burial 2 🗆 Cremation 3 🗆 Removal from State		matory`or other place)			20c. Location - City o			
Baltimo permit. Page Department of Important: It	y injur	1	4 ☐ Donation 5 ☐ Other (Specify) ☐ 1.  21. Signature of Funeral Service Licensee		emorial Ce						
<b>n</b> §8 <u>E</u>	g 6		Marle fle fit		Name and Address 555 Twin I			lumbia, M	D 21045		
			23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.  Immediate Cause (Final	eath. Do not ente	er the mode of dying,	such as cardiac o	or respiratory arres	t,	Approximate Interval Between Onset and Death		
Pπysici Med	_	Ì	disease or condition resulting in death)  a. Due to (or as a const	n tic					10 years		
Exami	-			ension	7				20 years		
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death ce		ician	23b. Was decedent pregnant in the past 12 months?  1	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year		
the de	laciled	Physician/Me	g ☐ Unknown								
S, F.C.	en ed p	ρ	Part II. Other significant conditions contributing to death but not	resulting in the u	ınderlying cause giver	n in Part I.			to the cause of death?  Probably 4  Unknown		
VITAI HECOFICS,  ysician: The law requires is certificate has been sig	nous :	Completed					24a. Was an		utopsy findings available completion of cause of		
HeC The la	baße	Som					autopsy perform 1  Yes 2	ed? death?			
Ital ician: certific	ector,	Be	25. Was case referred to medical examiner? 1		Othor	e of Death (Check			21. 11. 11.		
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ending eath. or: After		ficat 	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be	injury	M 1 ☐ Ye	es 2 🗆 No			, , <u>, , , , , , , , , , , , , , , , , </u>		
LIVISION tal or Attendir rs after death. al Director: Af	l fa ll fa	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,		
DIVISION OF VITAIL RECORDS, P.O. BOX 68 /60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and comprehend filled in but the financial director and a should be detailed to the build transit.	alli pajaid	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my kno only one) 3 Certifying Nurse Practioner: To the best of	tion and/or invest	tigation, in my opinion,	death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.		
Vithir To th	3		29b. Signature and title of certifier	0	20a License n	umbor	20	d Data signed (Mon	th Day Year		
		].	Pomnie Catalono	20	Hoo	40518		12/16/	2010		
			30. Name and address of person who completed cause of death (lt. 5450 Kno II North &	ten t	Colum	rbia, n	10 Suit	250	21045		
	State istra	<u>-</u>	31. Date filed (Month, Day, Year)  32. Registrar's Sig	nature	fac. of A						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month 12 Μ. Van Stone 2010 5:15 Kathleen рM Medical MC 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Nottingham 68 Stone Park Place 1715 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 X F Hours Director 218-68-2083 Yrs Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 12/27/2016 1 🗌 Yes 2 🎇 No Baltimore Nottingham MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 68 Stone Park Place 21236 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. , or P Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: Unite 1 Yes 2 No Specify. "natural", 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical Ψ 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Vanster Elementary/Seconday (0-12) College (1-4 or 5+) 12 Catholic Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gercke, Sr. Maureen Foley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 68 Stone Park Place , Nottingham, MD 21236 Jack Van Stone. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Parkwood Cemetery 4 Donation 5 Other (Specify) 12/31/2010 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tenioscler Physician/ a. Hypotensue A to (or as a consequence of) disease or condition Medical resulting in death) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit Exami or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 24 hours after death.

Puneral Director: After this certifical leted filled in by the funeral director. 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Vecember 30, 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
JAN 0 3 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death White Physician/ Month Duse, 6:33 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimon Cit 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, 1 □ M 2 🗷 Hours Min. Country) Director Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No dana 10e. Street and Number 10g. Citizen of What Country? Funeral 5600 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical raminer Be 17. Father's Name (First, Middle, Last), 18. Mother's Name (First, Middle, Maiden Surname) Hadrew Gaither Vashti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Baltimor Ave. ar 20a. Method of Disposition 20b. Place of Disposition (Name of Nata 20c. Location - City or Town, State cemetery, crematory or other place, Tinity Cemetery 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Freden 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ H days disease or condition resulting in death) edema Cerebral Medical Due to (or as a consequence of) Examiner thrembostepen Ihrenboti Sequentially list conditions, Physician/Medical Examiner If any, leading to immedicause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 Other (specify) Month Year 4 Pregnant 9 Unknown Pregnant at time of death 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Carcinomo 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an completed filled in by the funeral director, page 2 autopsy performed: 2 🗸 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No Certificate: To 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work Accident Investigation 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Rumber 23 188191579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Actt M.D. 31. Date filed (Month, Day, Year) 92..Registrar's State Registrar

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30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day (dep)) 32. Registrar's Signature		Σ	29b. Signature and title of certifier										1
Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day (Ger)) 2 20 32. Registrar's Signature		-	30 Name applicabilities of person	who completed cour	e of death (Itam	23a)	0.0.1	n.∟.			December	13, 20	
State 31. Date filed (Month, Day Keer) 3 2 Registrar  Registrar			Laron Locke MD. As			•	Street, Baltim	ore, MD 2	21201				
		ate	31. Date filed (Month, Day (eer)	0 3 2011 32. Re	gistar's Signatu	re A	2		0				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ White Jacqueline Rache1 2010 December 8:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Winfield Senior Constant Care, Inc. 8. Date of Birth (Month, Day, if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Massachusetts 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 😾 I Director 031-09-8173 95 Sep. Usual Residence of Decedent Department of Health and Mental Hygiene. In partners after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any injury or other traumatic event. In any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Carroll Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6518 Ridenour Way Apt 2D 21784 U.S.A. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican. etc. Armed Forces Black. White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Internal Revenue Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Renshaw White Doris M. Branch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mercedes Hunter (Friend) 6518 Ridenour Way Apt 2D Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 12-31-2010 Glen Burnie, Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lieensee 22 Name and Address of Facility Homes, Inc. 55 Twin Knolls Rd. Columbia, Maryland 21045 200000 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Sinus Immediate Cause (Final Syndrome Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): nding physician and use as the bunal-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy No Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Assited 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier - 29 - 2010 NNMwho completed cause of death (Item 23a) (Type, Print) Smite 114 21784 380 180 Gress

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Grace Emma White December 29, 2010 6:40 P. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford County Harford Memorial Hospital Havre de Grace . Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Hours Nov. 14, 1907 Baltimore, MD. 220-09-5096 **Director** 103 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-1 Harford County 1 Yes 2 No Maryland Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 415 S.Market Street 21078 United States "natural", or items idical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give White 3 - Widowed 4 - Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) **02** Teacher Education marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Ellsworth Miller Grace Emma Miller traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Havre de Grace, MD. 21078 Mr.Louis W.White (Son) 119 Flying Ebony Place permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State (Harford County) Friday, Dec. 31, 2010 Evans Fure al Order place)
Cremetion Services, Inc. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. **Reactul** Alternatives Funeral & Cremetion Center, P.A. .Lic.#M00677 2325 York Road Timonium, Maryland 23a. Rart 1. Enter he disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory grest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Cause (Disease or iinjury attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an page 2 s has performed? Yes 2 No ours after death.

leral Director, After this certificate I filled in by the funeral director, pagr or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner<sup>c</sup> Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 No 1 🗌 Inpatient 2 🗸 ER/Outpatient 3 🗌 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сопретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie address of person who completed ause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State JAN 0 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Theresa Wysocki 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 27, 2010 Theresa Wysocki 1917 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 320 S. Chester Street Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7, Age (In yrs, last birthday) **Funeral** Months Days oreign Hours Director CountryMaryland 218-26-0498 1 M 2**X**F 80 02/09/1930 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No is 23a or 28a-f show he notified at once. 28a-f show Maryland N/A Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 320 S. Chester Street 21231 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 x No Yes White 1 Yes 2 X No specify: Specify: 3 Widowed 4 Divorced If Yes, Give Year <u>م</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 10 Secretary Office 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Antoni Wysocki Alexandra Wisiewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) timore, MD Stanley Wysocki - Brother 403 Folcroft Street Baltimore, Maryland 21224 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Holy Rosary Cemetery 01/03/2011 Baltimore, Maryland Donation 5 Other Specify: permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 aplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a Atherosclerotic Cardiovascular Disease Complicated by Hypothermia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Medical UNPENDED **AMENDED** the attending physician hed for use as the burial Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE 23d, Date of delivery 3b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Physician/ Live birth Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 2 1 Yes 2 V No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available 24a. Was ar autopsy prior to completion of cause of has 2 s death? performed? certificate h ector, page ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this ဥ 1 Yes After 1 funeral 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Subject exposed to cold environment within 24 hours after death.

To the Funeral Director: A completely filled in by the fun 1 Natural **FOUND** Pending 1 Yes 2 ✔ No Dec 27, 2010 1905 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 320 S. Chester Street , Baltimore , MD determined (Specify) Townhouse / Rowhouse Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medic and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E December 28, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registra

ORIGINAL

2. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

State

31. Date filed (Mo

32. Registrar's Sig

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	Physicia	n/	Decedent's Name (First, Middle,	ŕ					2. Date	of Death	3. Time of Death		
	Medic	al	4a. Facility Name (if not institution,	Lynn Fra	<u>·</u>	etz	4.00.7		Dec	ember	104.	2010	11:20ам
أفحر	Examin	ier	Collingswood				4b. Gity, Town, o	Rockvi			4c. County of		tgomery
	Funeral Director			6. Sex 1 □ M 2 🔏 F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hours		of Birth th, Day, Yea	34	9. Birthpi Count Wash	ace (State or Foreign V) Cngton
	ow t	L	Usual Residence of Decedent  10a. State 10b. County			y, Town or Loc	nation		1.0.77	-			Od. Inside City Limits
	larylan <b>3a-f sh</b> ified a	ecto		tgomery	100.00	y, TOWIT OF LOC	Jation	Rockvi	1880				1 X Yes 2 No
:	a or 28 be not	E Di	10e. Street and Number				10f. Zip Code			10g.	Citizen of W		
:	ms 23	Funeral Director		Hurley A	Venue edent Ever in U.	9 140 1	Man Decedent of III	2085		w No	Lu s	u.s.	
Q	be lied within /2 hours after death with the Maryland and Hygiene. And Hygiene. Red other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ce event, the Medical Examiner must be notified at	by Fi	11. Marital Status 1 Ⅸ Never Married 2 ☐ Marrie	Armed Fo	orces? 2 🔼 No	li li	Vas Decedent of H f Yes, specify Cuba	an, Mexican, Pu	uerto Rican, etc	c.)	Black	- America , White, e	tc.
3	ours at atural" cal Exa	eted	3 Widowed 4 Divorced	If Yes, Giv Year or D			Yes 2 🗓 No			100	Specify:		White
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7	led within Hygiene. <b>other thai</b> ent, the N	Be C	17. Father's Name (First, Middle, La		+		Tea	cher	Name (First, M	idallo Maid	an Curnamal	Educ	cation
	I and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	은	17. Fauler 3 Haine (First, Wildow, La	William			16. Mother's			ce Hil	dahl		
<u>a</u>	should and N is ma rauma		19a. Informant's Name/Relationshi			1	g Address (Street						
ı,	I and 28 F Health Item 27 other tra		Linda Fraley - 20a. Method of Disposition			Place of Dispos	Oak Spr	Ī	Date		Location - 0		
2	rage 1 nent of 1 ant: If it ury or o		1 ☐ Burial 2 🛣 Cremation : 4 ☐ Donation 5 ☐ Other (20)		State Bal	timore Loud	on Park	ly 12	/09/20	0 B	ultimo	re, 1	Maryland
	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		21. Si nature of Funeral Service Lic	ensee M	00709	22	Name and Addre	ss of Facility ${\cal S}$	imple 1	ribu	te tun	eral	& Crem Ctr
	ad.		23a. Part 1. Enter the disease, or c shock, or heart failure. List on	ly one cause on ea	ach line.	h. Do not ente	er the mode of dyin	g, such as card	diac or respirat		•		Approximate Interval Between
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عممب	Examiner	L	Constalle but wer things	Due	Fail	LLYC	Tot	hriv	e				
7	Oğ.	Examiner	Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to	(or as a consequ	uence of):							
	physician and sthe burial transit	Exa	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):				_		$\top$	
3	physici the bu	edical	1	d									
	anding use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregna	incy	Ectopic pregnanc	27			23d. Date of delivery		
	the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 【 No 9 ☐ Unknown		nant at time of		Other (specify)	-y 			Mon	th I	Day Year
)	igned by	by	Part II. Other significant condition	s contributing to c	leath but not res	ulting in the u	nderlying cause giv	ven in Part I.					e cause of death?
SDIO,	been s	Completed								Was an	24b. W	ere autop	sy findings available
ולים לבו ביים ביים ביים ביים ביים ביים ביים ביים	cate has	Somp							 1 [	autopsy performed Yes 2	? de	rior to con eath? □ Yes	pletion of cause of
נים	certifica rector, i	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:			Oth	ace of Death (C	Check only one	)			
	er this	te: To	27. Manner of Death	28a. Date	Inpatient 2  of injury th, Day, Year)	28b. Time of injury	t 3 □ DOA 28c. Injun	4 Nursir y at	ng Home 5   28d. Desc		6 Other		
	tor; Aft the fur	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could no	ation				Yes 2 No	_				
	s after of Directed in by		4  Homicide determin	28e. Place	of Injury - At ho ing, etc. (Specify	me, farm, stre	et, factory, office			tion (Street or Town, St		or Rural I	Route Number,
Hoenit	within 24 fours after death.  To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 L Medical Ex	Physician: To the base	sis of examination	n and/or invest	igation, in my opinio	on, death occurr	red at the time,	date and pla	ace, and due	to the cau	se(s) and manner stated.
Totho	To the	Σ	only one) 3 L Certifying to 29b. Signature and title of certifier	Nurse Practioner:	To the best of my	y knowledge, d	29c. License	e number	<u> </u>	29d.	se(s) and mar Date signed		
	4		123		7 (0,		Doc	624	35		12/7	12	010
			30. Name and address of person with the second seco	o completed caus	se of death (Item	123a) (Type, P	To le Cul	Var 6	2 Ro	cki	ville,	M	20850
	Stat Registra	е	31. Date filed (Month, Day, Year)	32. R	legistrar's Signat	ture Line	State						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 30 per JVR G911 1/3/11 dk.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 21 - 2010 ALICE N/M/NANDERSON 2:20P М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 410 GARNER AVENUE CHARLES WALDORF Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. S Country) 155-18-5818 1 M 2 XF 100-12 2 - 1923 87 Yrs Director Usual Residence of Decedent 28a-f shov 10b. County notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES WALDORF 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 410 GARNER AVENUE 20601 U.S.A. items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 X Never Married 2 Married þ Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: BLACK "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working DEPT.OF\_NAVY permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me one. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S.GOVT. ADMINISTRATIVE ASST. 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN ANDERSON NANCY FERGUSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE DAY-NIECE 11190 INWOOD LN. WHITE PLAINS, MD. 20695 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State MT COMFORT CEM. 12-30-10 ALEX., VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licens 2. Name and Address of Facility RAYMOND FUNERAL SERVICE, p.A. MQ0479 LA PLATA, MD. 20646 Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Priysician/ -nanition disease or condition Medical resulting in death) Examiner vitARISM Sequentially list conditions cause. Enter Underlying neoplasm Pitvitary gland Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trans and attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed I 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Yes 2 🗷 No Other: 4 Mursing Home 5 - Residence 6 - Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending injury a er death. 1 Yes 2 No ☐ Accident Investigation the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide determined filled 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 29d. Date signed (Month, Day, Year) 12/21 0054044 MW who completed cause of death (Item 23a) (Type, Print) Linda Jefferson 2670 Crain Highway Suite 410 Waldorf MD 20601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Barke Registrar

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	State of Maryland / Department of Health and Mental Hygiene											41390		
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ISIOII Attending death. ctor: Afte	1	Za	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	e 290 Place of I	niurv - At ho	ome, farm, str	M reet. factor		Yes 2□No	28f, Location	(Street ar	nd Number or R	ural Route Number,	
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DIVISION OF VICE THE COURS, F.C. BOX 607 00, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit				nysician: To the best niner: On the basis										
thin 24 the F	Modi	Medical	one)  29b. Signature and title of certifier	and manner					e number			ate signed (Mon		
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2000			30. Name and address of person who	completed cause of	f death (Iten	n 23a) (Type,	Print)					0/11/		
MBIOT			31. Date filed (Month, Day, Year)	20 Beach	strar's Signa	o S	10	1/10	cda	WD	7	0647	)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12<sup>Day</sup> De Month Dorothy M. Brockington 2010 ar 1:00AM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Clinton Bradford Oaks Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Ye 260 68 6678 1 🗶 M 2 🗆 F Months Days Hours Min. Director 69 Nov Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 ☐ No Fort Washington Prince George's 10e. Street and Number 10g. Citizen of What Country?
United States 10f. Zip Code Funeral 20744 12021 Livingston Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Was Decedent Armed Forces? 1 ☐ Yes 2 XXNo Black, White, etc. þ 1 Never Married 2 Married Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2XXX No Specify: Completed 3XX Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "
any injury or other traumatic con-Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jimmy Lee Graham Marie Carson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 609 Mace Drive, Fort Washington, MD 207444 Kathy Smith (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State Dec 18, 2010 Ambrose, Georgia 4 Donation 5 Other (Specify) Vickers Rural 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Therescleration Physician/ Cardis vas disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical use as yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the sahould be detached to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 ZNo Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature State

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death  Reg. No.												IJ	1393	
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nor	e = 5		1 X Burial 2 ☐ Cremation 3 4 ☐ Qonation 5 ☐ Other (Sp		C	emetery, cre	osition (Name of matory or other p Heaven C		Date /15/2011	1	Location - C	-	·	
21. Signature of Fineral Service Licensee 1000720 22. Name and Address of Facility Hines-Rinaldi Fune									ral	Home, Inc.				
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Box 68760	ath cer attendi for use	cian/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	I death 3	☐ Ectopic pregna				23d. Date Mont		ery Day Year	
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Division of Vital Records,	al or Al s after o l Direct d in by		4 ☐ Homicide determin	ed 28e. Place of Inju	ry - At no c. (Specify)	me, tarm, st	reet, factory, offic	е		ation (Street and Number or Rural Route Number, or Town, State)				
_	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Ex	hysician: To the best of aminer: On the basis of e	xamination	and/or inves	stigation, in my op	nion, death occurre	d at the time, date	and plac	e, and due to	o the ca	use(s) and manner stated.	
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			30. Name and address of person with S. Ryapa	no completed cause of d	eath (Item 283	23a) (Type, 355m)	Print) Th AV-S	-703 ,	Baltin	nore	, MD	, 2	21209.	
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State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Det. 11, 2010 3:10р м Mary Ε. Bogan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Manor Care Silver Spring . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛂 F 099-32-4937 Hours Min. 93 Months 5 (M215 Par 599) 7 UETCA, N.Y. Director Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director Silver Spring MD Montgomery 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 2501 Musgrove Road USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Office Manager Be Father's Name (First, Middle, Last)
Frederick Dodge 18. Mother's Name (First, Middle, Maiden Surname) 2 Catherine O'Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2722 Iris Way, The Villages, Florida 32162 John F.Bogan/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🖾 Removal from State St.Mary's Cem. 12/16/2010 Clinton, New York 4 Donation 5 Other (Specify) ZNUNNING &ddr#cccraTH FUNERAL DIRECTORS-MYSLINSKI FUNERAL HOME 470 French Rd. Utica, N. Y13502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 1 Onset and Death Immediate Cause (Final Physician/ Aspiration pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Yrs. Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Day Month Year sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certification completed filled in by the funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dec . 13, 2010 D17874 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S.M.Nayer M.D. 3717 38th Avenue Cottage City, Md. 20722 S.M.Nayer M.D.31. Date filed (Month, Day, Year) 32 Registrar's Signatu State 14 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2010 Robert Barton 12:56 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Nursing & Rehab. Center Sandy Spring Montgomery 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Months Days 1 X M 2 🗆 F (Month, Day, une 16. Hours Country) **Director** 151-14-1059 June Arkansas Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Prince George's Maruland Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? Funeral 11310 Van Brady Road 20772 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 🛛 Yes 2 🗆 No 1944-Black, White, etc. <u>۾</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: 3 X Widowed 4 Divorced Completed 1946 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72., n and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Criminal Electrical Engineer Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Loy Edgar Barton Edith Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 11310 Van Brady Road, Upper Marlboro, MD 20772 Barbara Barton - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 12/14/2010 | Brentwood, Maryland 21. Signa ure f Funeral Se vice License 22. Name and Address of Facility Simple Tribute Funeral & Crem Ctr 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DAYS and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of) Examiner PNEUMONIA DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or liniplry ending physician and use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day signed by the a 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ATRIAL FIBRILLATION. PARKINSON'S DISEASE. DEMENTIA. 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should **HYPERTENSION** 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law performed? Yes\_\_2 X No 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at w<u>ork</u>? 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) d title of certifier 29b. Signature December 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANURADHA ARUN, M.D. CREORNIA AUG (ARING MI) 31. Date filed (Month, Day, Year) Registrar's Signature State 14 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shirley Louise Bell December 14 2010  $P^{M}$ :30 Medical 4c. County of Death
Carroll 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Westminster rroll Lutheran Village Healthcare 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Hours Min. Aug Por Year 1927 219-20-4183 Maryland **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director notified Westminster Maryland Carroll 1 Yes 2 XNo 10f. Zip Code 21157 10e. Street and Number 10g. Citizen of What Country? ò ems 23a or r must be r Funeral 101 Hahn Rd. USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian ı "natural", or iten edical Examiner r Armed Force Black, White, etc Completed by 1 Never Married 2 X Married 2 🔀 No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: 3 Divorced 4 Divorced Year or Dates marked other than "natu matic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Carroll County Schools life. DO NOT use retired Worker Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Earl Hann Hilda McGee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Jawn, State, Zip Code) 101 Hahn Rd., Westminster, MD 21157 Connie Bell/Daughter Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Bisporition (Variety Second 2016) 1 🗷 Burial 2 🗌 Cremation 3 🗍 Removal from State 12/14/2010 Westminster, Maryland Church Cemetery 4 Donation 5 Other (Specify) Printed Juneral Home and Chapel, P.A. Signature of Funeral Service Licensee 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ VANIAN disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Pregnant at time of death s been signed by the same should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; page 2 s autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to hedical 26. Place of Deat (Check only one) director, examiner? 2 No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No 24 hours after death Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours aft

To the Funeral Di

Completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and claim, and due to the namedal and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 912 Washington Rd., Westminster, MD 21157 Stephen J. Sikorski, M.D. 31. Date filed (Month, Day, Year) State DEC 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OWARD Physician 0 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** AUTIN U/21-OSPI If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 X M 2 □ F 214-38-5065 70 Director Aug. 8, 1940 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Modical Evantins Imits be notified at 10a, State 10b. County 1 ☐ Yes 2 X No Directo MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8922 Park South Drive 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver/Heavy Equipment Operator Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Edwin Bopst Helen Marie Payne ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Betty L. Bopst (Spouse) 8922 Park South Drive, Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State All County Cremation | 12/10/2010 | 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licenşee HAIGHT FUNERAL HOME & CHAPEL, PA EXCU M00764 PO Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Dear 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final ARCINOMA **Physician** 10.-1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
□ Live birth 2□ Fetal death
□ Pregn*a*nt at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) ed by the detached t Division of Vital Records, P.O. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy perform certificate 2 □ No 1 ∐ Yes 2 X No 1 ☐ Yes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Mapatient Certification: To After the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1. Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director; Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier Date signed (Month, Day, Year) WJL 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) 31. Date filed (Month, Day, Year Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $^{3.\,\text{Time of Death}}_{11:35p}$ Physician/ 20ÎÖ Marie Bennett Evelyn December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Carroll Westminster Golden Living Center Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 77 A 8. Date of Birth Funeral (Month, Day, 1 Days Min. 213-44-8579 1 🗆 M 2 💢 F VA Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Westminster MD Carrol1 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA items 23a Funeral 21157 605 Gahle Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black White etc ō þ 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 X No Specify. permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nanny Rose Stevenson James Crockett Lester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 Gahle Ct., Westminster, MD 21157 19a. Informant's Name/Relationship (Type, Print) Martha Pohlhaus (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Grandview Memory Garden 12-13-10 1 X Burial 2 Cremation 3 Kemoval from State Tazewell, VA 4 Donation 5 Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel Signature of Funeral Service Licensee ▶ Page Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician are use as the burial-Physician/Medical yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 X Natural 5 Pending 1 Yes 2 🗌 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29h, Sid ture and title of certifie 29c License numbe JJL 2 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 10 15 399

Dianne Bowie State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 3, 2010 1647 hrs **Medical Examiner** Dianne 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8irth (MM/DD/YYYY) 9. 8irthplace (State or **Funeral** Months Days Hours Min. Director 1 M 2 X F Country) 577-74-0460 Yrs 56 DC 20, 1954 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 23a or 28a-f show e notified at once. 1 X Yes 2 No Prince George's Maryland Hyattsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2703 Nicholson Street # 201 20782 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 14. Race - American Indian, 8lack, 12. Was Decedent Ever in U.S. ural", or items ? ıminer must be r If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married 2 X No 1 Yes African Americar 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry d other than "natu Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 1 nent of Health and Mental Hygiene.
ant: If item 27 is marked other than ", or other traumatic event, the Medical E Itimore, MD 21215-0036 llth Stewardess Amtrak 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Harry Bowie Mattie H. Burroughs 19a. Informant's Name/Relationship (Type, Print ) ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Pinkney - Nephew 3621-22nd Street SE Washington, DC 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dec. 16. Washington National 2010 Suitland, Maryland Donation 5 Other Specify: 22. Name and Address of Facility 21 Sign of F eral e Licensee Stewart Funeral Home, Inc. d 4001 Benning Road NE Washington, DC Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** 8etween Onset and failure. List only one cause on each line /Medical Death Cirrhosis Of Liver Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27 per me g911 1-20-11 vt X UNPENDED attending physician or use as the burial Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 V No 3 Probably 4 Unknown Completed s peen s 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has death? performed? 1 🗸 Yes this certificate ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Division of Vital Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other 1 Yes 2 No After the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27 Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City hours after 3 6 Could not be Suicide or Town, State) c Funeral I (Specify) 4 Homicide within 24 ho

To the Fun

completely f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 5, 2010 ni Usul 1 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DEC 1 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:03 A<sup>M</sup> HELEN BALABAN DEC. 15 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY BETHESDA CARRIAGE HILL-BETHESDA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Days | Hours | Min. | May 6, 1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔽 F 185-16-2017 89 Pennsylvania Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ▼Yes 2 No MD Montgomery Bethesda Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20817 U.S.A. 7307 Nevis Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. \$ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor Kohne Alex Mitchell P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stephen Balaban Item 27 I 7307 Nevis Rd. Bethesda, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages t Department of H Important: If Iter any Injury or oth 1 ☐ Burial 2 X Cremation 3 □Removal from State 12/18/10 Cremation Center Chantilly, VA 4 Donation 5 Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service ki Mente Murphy FH 4510 Wilson Blvd. Arlington, VA 22203 Suc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PHEUMONIA /Medical Due to (or as a consequence of): **Examiner** DYSPHAGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed DEMENTIA burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1∐ Yes 2√D No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 ▼ No 2 ER/Outpatient 3□ DOA 4 v Nursing Home 5 Residence 6 Other (Specify) မ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours and To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No M 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D35579 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Susan J. Miller,

31. Date filed (Month, Day, Year)

**BEC 1 6 2010** 

DHMH 17 Rev 1/2001

20814

Bethesda, MD

MD 8218 Wisconsin Ave. #305

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 4 40 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Burndetta Blank Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany WMHS-RMC Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) W.Va. "Sep 16," 1923 1 □ M 2 □**x** 234-36-9631 Director 87 Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits the Medical Examiner must be notified at Director MD Cresaptown Allegany 1 Xes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14911 Howard Street, S.W. 21502 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Ño If Yes, Give Year or Dates Specify: Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillie (Wolfe) Johns Charles Johns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 14801 Hay Street Cresaptown MD 21502 Keith Blank Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Sunset Memorial Park 12/27/2010 MD Cumberland 4 Donation 5 Other (Specify) f Funeral Pervice Licensee Signature 3 22. Name and Address of Full Veral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Intra cereby Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Examine Dire to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attanding attacking an executed. Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the bunal-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ signed by the atte in the past 12 months? Month 4 🛄 Pregnant at time of death 1 Yes 2 Unknown No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dementia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ၉ 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1XX Natural 5 Pending injury 1 ☐ Yes 2 ☐ No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number nomocks MD 00055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WONSOCK SHIA Walsh Ro BISHOP Cumberland 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Varke. Registrar

**DHMH 17 Rev 7/2009** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Burton Helen Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WMHS-RMC Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Country) WV **Funeral** 8. Date of Birth 1 □ M 2 □ ¥ Min Months Dec 15. Director 215-36-7598 Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 28a-f 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 21502 135 N. Mechanic Street Apt. 8 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Pes 2 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: Completed 3 Nidowed 4 Divorced white the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important If item 27 is marked any injury or call. homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Hollie Wagoner Othello (Burkhart) Wagoner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 66 Corriganville MD 21524 Robert Wagoner brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Fort Ashby Cemetery WV Fort Ashby 4 ☐ Donation 5 ☐ Other (Specify) 21. Si nature of Funeral Service Licenses 22. Name an Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Final Physician. 75 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 Yes 2-1 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this funeral ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury eral Director: A 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral D edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 🖟 Çêrţifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0033280 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 035 AVENUE CUMBERLAND MD 21 IPTA M.D GI

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

2/0

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OWARD 0530 12 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 1 1 - 2 7 - 1 9 6 1 M 2 □ F Days Hours Min 217-80-1063 49 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amortant: If item 27 is marked outher than "natural", or items be notified at an injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CHARLES MD. LA PLATA 1 🏋 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral P.O.BOX 2254 20646 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 ☐ Married Completed by Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th ELMER ELEC.CO ELECTRICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES VINCENT BUTLER FLORENCE GERTRUDE WOODLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY WHEELER-SISTER P.O.BOX 588 MECHANICSVILLE, MD. 20659 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 

■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ST. MARY S CEMETERY 12-23-10 NEWPORT, MD. 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Funeral Service Licensee MQQ479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence or): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Tes 2 🗷 No ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific V1438 NSE HWY ANNAPOLIS MONYOI HAR 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		State of Maryland / Department of Health and Mental Hygiene Operation of Posts											41404					
		Registrar Certificate of Death								Date of De								
Physicia		ANNA TEE CTARV										Month Decem	Da	15	Year 2010			
Medic Examin		4a. Facility Name (if	no <i>t institutio</i> r					4b. City,	Town, or	Location of D								
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Funeral Director		5. Social Security Number 6. Sex 1 1 1			1 2 X F	. Age <i>(In yr</i> s. <b>7</b> 3	last birthda Yrs	Months	Days	If Under 24 I Hours N		Date of Birl (Month, Da 04/02/		<sub>7</sub>	Cou	n <i>tr<u>y</u>)</i>		
		Usual Residence of								04/02/			nai					
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fiurty or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State 10b. County				10c. City, Town or Location												
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with th	Funeral Director	6093 Quartz Circle								<b>7</b> 02						-		
items er mu	Fun	11. Marital Status	dar CZ			ent Ever in U.	ver in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-							14. Race	ce - American Indian,			
after d I", or i	by	1 Never Marri	1 Yes 2 If Yes, Give	2 ☑ No 1 ☐ Yes 2 ☑ No Specify: Speci								-						
atura cal Ex	Completed	3 X Widowed	15. Decede		Year or Date	es.	16a. De	cedent's Usual Occupation re kind of work done duning most of working  16b. Kind of Business Industry										
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ntal H ed ot ever	To B	17. Father's Name (F												Ac. County of Death Frederick  1937  4c. County of Death Frederick  1937  10d. Inside City Limits 1 Yes 2 No  10g. Citizen of What Country?  11d. Inside City Limits 1 Yes 2 No  10g. Citizen of What Country?  11d. Race - American Indian, Black, White, etc.  Specify: white  18b. Kind of Business Industry  18b. Kind of Business Industry  18c. Kind of Business Industry  18c. Kind of Business Industry  18c. Kind of Business Industry  18c. Kind of Business Industry  18d. Kind of				
ould b id Mer mark maric	ľ	Charles Murray  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addre						ailing Address	Street a			ed Har		hotel faiden Surname) ris City or Town, State, Zip Code) ck, MD 21702 20c. Location - City or Town, State Frederick, MD asford Funeral Home ck, MD 21701 st, Approximate Interval Between				
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of Heg of Heg fitem rothe		20a. Method of Disp 1 XBurial 2	osition			20b.	Place of Dis	sposition (Nar rematory or o	ne of		Date							
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permi Depar Impo any ir		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Keeney & Basford Funeral Home  106 E. Church St., Frederick, MD 21701																
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Physician/											lus	rgs						
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ding F th. After funer	Certificate:	1 Natural 2 Accident	5 🗌 Pendi		28a. Date of (Month)	Day, Year)		Time of 28c. Injury at 28d. Describe how injury occurred injury M 1 1 Yes 2 No										
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ital or urs aft ral Dir lled in		building, etc. (Specify)								City or Town, State)								
Hosp 24 hor Fune eted fi	Medical	(Check 2	☐ Medical	Examiner:	On the basis	of examination	on and/or in	estigation, in	my opinio	on, death occur	irred at the	time, date a	and place	e, and due	to the c	ause(s) and manner stated.		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Σ	only one) 3 29b. Signature and			ractioner: 10		y KHOWIECIC	290	. License	e number			29d Da	ate signed	(Month.	Day, Year)		
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/		30. Name and addre	ess of person	who comp	oleted cause	of death (Iter	n 23a) (Typ	e, Print)	0 ' ^-	10.00	, F	- ام	ni.	7V	MA	21701		
() Stat		31. Date filed (Month	h, Day, Year	Suc	32. Reg	gistrar's Signa	ature	YITCK	11/6	1700		Cae	110	1	עווו	QIIVI		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2010 ar Nellie P. Custer 19 Dec. 6:50p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Talbot Memorial Hospital at Easton 8. Date of Birth (Month, Day, Year) Feb. 8, 1918 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 92 Director Kentucky 332-16-2750 Usual Residence of Decedent 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Medical Examinate the conflict an once. Preston Caroline MD 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21655 23550 Gilpin Point Road United States Funeral 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Ernest Christy Minta Susan Conn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 579, Preston, MD 21655 19a. Informant's Name/Relationship (Type. Print) Sandra Ann Custer/Daughter 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 → Burial 2 □ Cremation 3 □ Removal from State 12/27/10 Howard Cemetery Tannery, KY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityFramptom Funeral Home 216 North Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final intardion **Physician** mydardial 5 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 1 ☐Yes 2 ☑No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier

State Registrar Tallan

31. Date filed (Month, Day,

Mother

Year)

2 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

of Vital Records,

Division

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Registrar's Signature

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al Exami		Chad Dulin Clark				nth Da c <b>ember 18</b>		2215 hrs			
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Baltimore, MD 21215-0036  permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importanti: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addres David James Clark/father  10165 Log									
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lore ges 1 at of H fr. If i		1 Burial 2 Cremation 3 Removal from State Denton Cemete			Dec. 23	3, 2010	Denton,	, Maryland			
Baltimore, permit. Pages 1 ar Department of Hec Important: If ite Injury or other tr	1	4 Donation 5 Other Specify:  2): Signature of Fungral Services Licensee  22. Name an		of Facility	Moor	e Funer	al Home,	P.A.			
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<sup>o</sup> hysician		23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.	e of dying,	such as car	rdiac or resp	iratory arrest,	shock, or hear	t Approximate Interval Between Onset and Death			
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ding Ph	Ë	27. Manner of Death 28a. Date of Injury (Month, Day Sear) 29b. Time of Injury (Month, Day Sear) 2200 hrs	I	Yes 2	Driv	er auto au	ito collision				
SiOl Atten r death	Certification:	2 Accident Investigation 28e Place of Injury - At home, farm, street, factor	ory, office I	building, etc	c. 28f.	Location (Str	eet and Numbe	r or Rural Route Number, City			
Divi	🚆	Suicide 6 Could not be determined (Specify) Major Road / Highway				or Town, Sta re Highway	te) W/O Downs	Station Road, Denton, MD			
Hospil Hospil Houn Funer		29a. Certifier	the time, d	ate and pla	ice, and due	to the cause(	s) and manner	as stated.			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely littled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinio	n, death oc	curred at the	time, date ar	nd place, and du	ue to the cause(s)			
F > F 3	×	29b. Signature and title of certifier		se number			29d. Date signe December	ed ( <i>Month, Day,</i> Year)			
		Houping Melskall	U.C.	.M.E. 			December				
		30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn S	Street. E	Baltimore	e, MD 212	01					
		31. Date filed (Month, Day Year) 42. Registrar's Signature									
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Registrar

State Registrar 31. Date filed (Month

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia Month ase Beaut 1:45 PM 2010 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Julia Manor Health Care Center itagers to w. ~ Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🂢 F Months Days Hours 219-34-6534 Pennsylvania Director **T**936 Usual Residence of Decedent or 28a-f show 10a. State "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland | Washington County Hagers town 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 333 Mill St. 21740 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Specify: White Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natuury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Hunerford-daughter 304 S. Locust St. Hagerstown, MD 21740 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date permit. Page 1 of P cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Important: It any injury or Smithsburg Crematory | 12-23-2010|Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Supremental Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvld North Hagerstown, MD 21742 1331 23a. Part 1. Enter the disease, or complications that caused the death too not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) hronic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 1 ☐ Yes ∠↓ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed i 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? After this certificate Yes 2 N 1 🗌 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Director: After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

\*\*Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3MillStreet Haberstown MD 21740 State Registrar's Signa Registrar

DIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Physician/ 0:09a M Gloria Rachel Dease Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death University of MD Medical Baltimore Center If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 1 🗆 M 2 🛛 F Days Hours (Month, Day, Year) Director 082-32-3562 4-26-1943 Washington DC "natural", or items 23a or 28a-f shov idical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director 1 □XYes 2 □ No MD Temple Hills PG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3420 Rickey Ave Apt# 20748 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐**X**No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾No Specify: SpecifyBlack 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Dept. Of Homeless Svc. Social Worker 12th Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Bass Lutisha Ellerbe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrell Dease/Son 404 Oakwood St., SE Washington, DC 20032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State Lincoln Mem. Ceme 12-18-201 Suitland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Hme of Funeral Service L 10583 Middleport ln White Plains a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Cardio Physician/ onic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death Yes 2 No 9 Nknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: |၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after deau...
ral Director: After 1 Vatural injury 5 Pendina ☐ Accident 1 Yes 2 No investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) brene 31. Date filed (Month, Day, Year) 32. Regiotrar's Signature State Registrar

DHMH 17 Rev 7/2009

14. Race - American Indian, Black, White etc White Specify 16b. Kind of Business/Industry Commercial Drywall 18.Mother's Name (First, Middle, Maiden Surname) Domenica Caminiti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Wetherfield Ct. Potomac, MD 20854 20c. Location - City or Town, State Brentwood, MD 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a, Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death Compressional asphyxia complicating hypertensive atherosclerotic cardiovascular disease Physician/Medical 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 No 3 Probably 4 ✔ Unknown pleted 24b. Were autopsy findings available 24a. Was an prior to completion of cause of performed?

✓ Yes 2 No death? Comi 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 PR/Outpatient 3 DOA 1 🗸 Yes No 28a. Date of Injury FOUND: Toy, Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27 Manner of Death Subject pinned under garage door Certification FOUND: 1 Natural 1 ✓ Yes 2 No 5 Pending 1330 hrs Dec 9, 2010 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be Suicide or Town, State) 2310 Perkins place, Silver Spring, MD (Specify) Other (specify) Garage Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. December 10, 2010 e and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature (ear) State 2010 OCME **ORIGINAL** DHMH 17 Rev 1/2001

3. Time of Death

1404 hrs

10d. Inside City Limits

1 X Yes 2 No

9. Birthplace (State or

oreign Country) DC

Registrar

After this certificate has

within 24 hours after death To the Funeral Director:

To the Hospital c

10

**OCME 2006** 

or Attending Physician:

funeral director,

the f

completely filled in by

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #26 Per PHY G911 1/13/2011 JH
State of Maryland / Department of Health and Mental Hygiene | | | for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1<u>3</u> Month Physician/ George Paul Duvall, Jr. 1:36 2010 Ам December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cottage City Prince George's 3713 40th Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours (Month, Day, 1 X M 2 - F 86 578-20-9773 Yrs Washington, DC Director <u>June</u> Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho Director 1 X Yes 2 No Cottage City Prince George's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 3713 40th Avenue 20722 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☒ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Year or Dates. 1943-1946 Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Hardware Vice President 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Bennett eq pinous George Paul Duvall, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 Timothy F. Duvall / Son 782 Stevenson Road, Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12/18/2010 Brentwood, Maryland Fort Lincoln Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility 4739 Baltimore Avenue Signature of Funeral Service License Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final 10 (au Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin Due to (or as a consequence of): resulting in death) Last physician a sthe burial-t Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day signed by the a d be detached f g 
Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 4 No death? certificate Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ER/Outpatient 3 DOA 1 Inpatient 24 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28b. Time of 28c. Injury at 28a. Date of injury 28d. Describe how injury occurred Certificate: injury (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending M Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cer 20 NA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6504 Kenilworth Avenue, Suite #200, Riverdale, MD 20737 Madhu Mohan V. Katikineni, 31. Date filed (Month, Day, Year) State 7 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 057 M ANSU ecemba Medical 4a. Facility Name (if not institution, give str **Examiner** City, Town, or Location of Death 4c. County of Death 100,001 wers burn If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) 1 ☐ M 2🛣 F Days Hours **Director** 232-76-9631 West Usual Residence of Decedent or 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shoraumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Washington Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12431 Gemstone Drive 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th <u>Postal</u> Worker TICPC traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Walker permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Geraldine Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erika Lucas/Daughter 16503 Ariel Court Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗌 Burial 2 🔀 Cremation 3 🗋 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory12/20/2010 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home Moun 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 1345/01 Onset and Death Physician/ disease or condition Medical resulting in death) r as a consequence of): Examiner INTON (ON) Sequentially list conditions, Examiner it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months? Month signed by the at d be detached fo Pregnant at time of death Day Year Unknown Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performe Send obstrutive this certificate Ne Hospon...
in 24 hours after death.
the Funeral Director. After this certificate.
.......in by the funeral director, pe 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Inpatient 2 ER/Outpatient 3 DOA ၉ 1 L Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 of death (Item 23a) (Type, Print) 15 32. Registrar's Sign State Registrar

10-09	9657		
John	Scott	Eberman	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 41413

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certifica			montai		g. No.				
Physici edical Exami		Decedent's Name (First, Middle,Last)				2. Date of Death Month December		3. Time of Death 0834 hrs				
		4a. Facility Name (if not institution, give street and number) 2439 Fairmount Road # 18	<del> </del>		. City, Town, or L Hampstead	ocation of De		4c. County of D	eath			
Funeral Director		220-82-0736 <sub>1XM 2</sub> F	In yrs. last birth 53	nday) Yrs.	If Under 1 Year Months Days	If Under 24I	8. Date of Birt Min. 02/16	/1057	. Birthplace (State or Foreigr Country) Maryland			
d Bow any		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  Maryland Carroll  Hampstead										
the Marylan  or 28a-f 3l	Director	10e. Street and Number 2439 Fairmount Road						og. Citizen of What United St				
s, MD 21215-0036 fand 2 should Elifed within 72 hours after death with the Maryland faulth and Montal Higtene. fem 27 is marked other than "natural", or items 23a or 28a-f she fraumatic event, the Medical Examiner must be notified at once	/ Funeral	3 Widowed 4 X Divorced If Yes, Give Year	ver in U.S.	U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No specify:  1 Specify:								
136 hin 72 hours at e. than "natural edical Examin	Completed by	15. Decedent's Education (Specify only highest grade compl  Elementary/Secondary (0-12) College (1-4 or 5+)	) d	Decedent's	Usual Decupation t of working life. I	on (Give kind		16b. Kind of Busin	ess/Industry ive repair			
21215-0036 uld be filed within 72 Mental Hygiene. marked other than t event, the Medical	Be	17. Father's Name (First, Middle, Last)  John Henry Eberman	<u> </u>			Mary A	me (First, Middle, M . Huffmar	1	,			
e, MD 21 1 and 2 should Health and Me item 27 is ma	10	19a. Informant's Name/Relationship (Type, Print ) Mary A. Huffman / mother	30	)500	Bennett	Road		ry, Maryl	and 21804			
Baltimore, permit. Pages 1 ar Department of Hea Important: If itel injury or other tr		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:	cremato	ory or othe	emation	1:		or Town, State  d, Maryland				
Physician  Physician	/ (	21. Signature of Funeral Service Licensee  21. Signature of Funeral Service Licensee  22. Signature of Funeral Service Licensee  23. Part I. Enter the disease, or complications that caused the	M01072	934		Main St		mpstead,	Maryland 210			
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Diabetic or condition resulting in death)  Due to (or as a consequence)	Ketoaci						Between Onset and Death			
	Examiner	Sequentially list conditions, b.										
'60, rate be executed bhysician and re burial - transit	Medical Ex	d.		nor	ME G911	1/11/1	1 MAM					
.O. Box 68760, that the death certificate be ex need by the attending physician detached for use as the burial.	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome 1 Live birth 4 Pregnant at tim 9 Unknown 9 Unknown	of pregnancy 2	Feta	death 3 [	Ectopic pre		23d. Date of del Month	ivery Day Year			
ords, P.O. E w requires that the case been signed by the should be detached	Ď	Part II. Other significant conditions contributing to death b	out not resulting	in the un	derlying cause gi	ven in Part I.	23e. Did to		e to the cause of death?  Probably 4  Unknown			
Records The law requi cate has been page 2 should	Completed						24a. Was a autop: perfor	sy prior med? dear	e autopsy findings available to completion of cause of h? Yes 2 No			
Vital Rec bysiciao: The this certificate I director, page	æ	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ☐ ER/Qui	itpatient		of Death (Che	rsing Home 5	Residence 6	Other: Scene			
Division of Vital Records, P.O. Box 687 Hospital or Attending Physiciae: The law requires that the death certific 44 hours after death.  Funeral Director: After this certificate has been signed by the attending I lely filled in by the funeral director, page 2 should be detached for use as the content of the content of the page 2 should be detached for use as the content of the c	Certification: To	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year Investigation Page 1)	28b. T		am 1 Ye	at Work?	28d. Describe h	ow injury occurred to low	enviromental temperature			
Divis Hospital or A 24 hours after Functal Directely filled in by		4 Homicide	use tra	ailer			or Town, St 2439 Fa	airmount	r Rural Route Number, City Rd. Hampstead			
To the Hos within 24 h To the Fur completely	Medical	(Check only one)  2 Medical Examiner: On the basis of examinary and manner stated.										
351	ž	29b. Signature and title of certifier  When the Hall of M.			29c. License O.C.N			29d. Date signed December 16	(Month, Day,Year) , 2010			
U		Name and address of person who completed cause of dea     Carol Allan, MD	ner 111 F	Penn St	reet, Baltimo	re, MD 21	201					
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's UEC 2 1 2010	Signature	ba	Les .							
OHMH 17 Rev 1/2	001	OCME	ORI	IGINAL								

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			Registrar  1. Decedent's Name (First, Middle	e, Last)		Certificate of Death  2. Date of Death							9: Fillio 91			
	Physicia Medio		Jerry	Jerry O'Neal Fowler							Decembe	er 8	2010	9:27	A M	
	Examin	ıer	4a. Facility Name (if not institution	_					Location	of Death		40	County of D			
- Arriga	Funeral		20127 Watersid  5. Social Security Number	7. Age (In yrs. la	ıst birthday)	If Unde		OWII If Under	24 Hrs.	8. Date of Bir		Montg 9.	Birthplace (State of	or Foreign		
	Director		426-64-1210 Usual Residence of Decedent	1 <b>∑</b> M 2 □ F	72	Months Days Hours Min (Month Da						Year)	38 Mi	Country) SSISSIPP	i	
	and show	Į.	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside C	ity Limits	
	Maryl 28a-f otifie	Director	Maryland Montg	omery	mery Germant			town						1 🗌 Yes	2 💢 No	
	th the 3a or t be n	a D	10e. Street and Number	<b>.</b>			10f. Zip						. Citizen of What Country?			
	ath wi	Funeral	20127 Watersid		edent Ever in U.S	i. 13. V	Vas Dece	208 dent of Hi		igin? (Spe	cify Yes or No-		USA 14. Bace - A	merican Indian,	_	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 🗶 Mail 3 Widowed 4 Divorced	rces? 195	No I J J U			as Decedent of Hispanic Origin? (Specify Yes or No- yes, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 No Specify:				Black, W				
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12	/ithin / iene. r than the M	Sol	Elementary/Seconday (0-12)	College (1	-4 or 5+)		ice Manager  18. Mother's Nar					awn Ca	re			
br	be filed w ental Hyg ked othe ic event,	Be	17. Father's Name (First, Middle,	Last)					18. Moth	3. Mother's Name (First, Middle, Maid			Surname)			
Maryland	ild be filed within Mental Hygiene. Iarked other tha atic event, the N	욘	Clarence O'De	11 Fowler	l Fowler			Erin Ra			ggett					
Mar	2 should th and Mi 27 is mar traumati		19a. Informant's Name/Relations				Ü				Route Numbe					
ďΣ	and 2 s Health tem 27 other tra		Nedra E. Fowle 20a. Method of Disposition	r/wiie	20b. P	lace of Dispo			נע מפ		German	T		or Town, State		
ШŌ	Page 1 nent of I ant: If it ury or o		1 ☐ Burial 2 🕅 Cremation 4 ☐ Donation 5 ☐ Other (		State	emetery, cren ropoli				12/0	9/2010	Ale	exandri	La, VA		
Baltimore,	e injust		21. Signature of Funeral Service			22	. Name ar				eVol F					
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Same	Medical Examiner		disease or condition resulting in death)		(or as a consequ		117 1	IDIO	313					Tears		
7.	Examiner	-e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):											-		
	Sit ed	Examine	if any, leading to immediate cause. Enter University Cause (Disease or iinjury	Due to	Size to (5) as a contraduction on.											
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90	ite be i hysicia he bur	d										<u> </u>				
68760	ath certificate be executed attending physician and for use as the burial-tr-nsit	/Me	IF FEMALE:	23c. If yes, out	come of pregnar	ncv					-		00   Data of	d=15		
	de de	Physician/Medica	23b. Was decedent pregnant in the past 12 months?   1										23d. Date of Month	,	Year	
P.O.	Attending Physician: The law requires that the de redeath. ector After this certificate has been signed by the by the funeral director, page 2 should be detached			ulting in the u	e underlying cause given in Part I. 23e. Did					d tobacco use contribute to the cause of death?						
ds,	quires sen sig ould b	ted	Diabetes								1 🗆	1 Yes 2 X No 3 Probably 4 Unknown				
COL	law re has be e 2 sh	Completed by									24a. Was auto			autopsy findings a to completion of c ?		
R	sician: The law s certificate has b lirector, page 2 s		25. Was case referred to medical					00 01	as of Doo	ath (Chaple	1 L Yes	2 X N		Yes 2 No		
/ita	siciar s certif	To Be	examiner?  1 Yes 2 X No	Hospital:	Inpatient 2 🗆	FB/Outpatier	t 3 🗆 D	Othe			neck only one)    Home 5 X Residence 6 □ Other (Specify)					
of/	ding Phys h. After this funeral di		27. Manner of Death	28a. Date		28b. Time of injury		8c. Injury	at		28d. Describe					
ion	tendin leath. or: Af the ful	ifica	2 Accident Investi	gation			М	1 🗆	Yes 2	_						
Division of Vital Records,	p # # =		4 Homicide determined determined determined 286. Place of injury - At nome, farm, street, factory, office building, etc. (Specify)									vn, State	ı) 		per,	
	Hospital	Medical	(Check 2 Medical I	Physician: To the b Examiner: On the bas Nurse Practioner:	sis of examination	and/or invest	igation, in	my opinio	n, death o	ccurred at	the time, date a	and place	e, and due to the	ne cause(s) and ma	nner stated.	
	To the within To the Comp	2	29b. Signature and title of certifie	r				. License		, , , , , , , , , , , , , , , , , , , ,				nth, Day, Year)		
0	25		> Yoshl AT	BALL MD			D	5331	1			Dece	mber 8	, 2010		
-			30. Name and address of person					A #	212	Coit	horobin	ro	MD 208	77		
	Stat	e	Joseph A. Ball 31. Date filed (Month, Day, Year)	32 R	egistrar's Signat	me /	ROA .	u, #	213,	Gall	HET SDU	Lg,	TID 200			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20<sup>4</sup> f to 10:25 AM Henry Lawson Fitzgerald Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's St. Thomas More Hyattsville, MD 5. Social Security Number 6. Sex 1 **X** M 2 D F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Days Hours **Director** 3*[267193*0 VA 80 386-26-7628 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ▼ Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4825 Ninth Street, N.W. 20011 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1950-11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Ş 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: African American Completed 3 Widowed 4 Divorced Year or Dates. 1953 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 yrs Elementary/Seconday (0-12) Pest Controller Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlie Fitzgerald Alease Monroe Jeter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Fitzgerald (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7 12/13/10 Gladys. V McGule Funeral Servi Washington, DC 20012 Family Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thompso 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Arterior clerchic Cardwascular disease or condition resulting in death) ONN Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Intracerchial Hemorrhage Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown EncephalopaThy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Respiratory failure 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at w<u>ork</u>? Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ame and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Y 42031 DEVOREMI Year State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene- U | U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carroll Reece Ferrell 4:00 2010 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sligo Creek Nursing Home Takoma Park Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 🖾 M 2 🗆 F Months Days Hours Min. Country)
Tennessee 83 Director 408-36-2144 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Maryland Prince George's Hyattsville 1 
Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3701 Kennedy Place 20782 USA 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. ş 1 Never Married 2 Married within 72 hours after If Yes, Give 1945–1952 Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: White "natural", Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Engineer Construction 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evan Ferrell Lillie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale E. Ferrell / Son 80 Gentry Court, Annapolis, MD 21403 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 12/14/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue RAY Kosens Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Prostate Cancer Months Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed ysician and e burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ending physical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) atter for u in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Anemia 24a. Was an autopsy performed' 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director. It 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes Other: 2 🔀 No မ 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗀 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🖟 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 12/13/2010 D28656 (1) pp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, 15245 Shady Grove Road, #130, Rockville, MD 20850 32. Registrar's Signature 31. Date filed (Month, Day, Year Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 19, 2010 Day **Physician** 45 PM Ann Fiedler Helen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** washington Kavenwood Lutheran Village Hagerstown der 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. las birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Months 1 ☐ M 2 💢 F Hours Director 5/25/1922 Pennsylvania 176-61-6190 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expraise must be notified at 1 □Yes 2 X No Directo Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1334 Keener Rd. 21742 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. be filed within 72 hours after ntal Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Sulewski ဥ Suleski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n Alfred Fiedler Jr./ Son Briarcliff Lane Frederick, Maryland 21701 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or 12/23/2010 Hagerstown, Maryland 4 Donation 5 Dother (Specify) Rest Haven Cemetery 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licenses 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician min. disease or condition resulting in death) Maria /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 262 No 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2411No 1 □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1□Yes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number on 30 Name and address of gerson who ampleted cause of death (Item 23a) (Type, Print) Hagesten MD21740 36 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

3)U

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2  $\mathbf{p}^{\mathsf{M}}$ John Lee Green 10 2:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Marlboro 13310 New Acadia Lane #203 PG 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 XM 2 □ F Months 578-22-7847 95 Yrs. Mississippi Director 1915 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at MD PG Upper Marlboro 1 X Yes 2 ☐ No ۵ 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō 27 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b Funeral 13310 New Acadia Lane #203 20774 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Barber Private 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be fi t of Health and Mental If item 27 is marked ٥ Walter Green Alice Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norva Jackson/Daughter Cameron Grove Blvd #307, UpperMarlboro MD injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 and Department of Hambortant: If ite any injury or ot 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/15/10 Lincoln Memorial n Memorial ! 12/15/10| Suitland MD 22. Name and Address of Facility Taylors II Funeral Home 21. Signature of Puneral Service Licens 10583 Middleport Lane White Plains MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complications t Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Dementia Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying <u>a</u> Due to (or as a consequence of) sician and burial-transit Exami Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β Adenocarcinoma of Prostate 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗶 No 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, æ Hospital 2 **X**No Other: 1 Yes 4 Nursing Home 5 X Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DO/ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 X Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide To the Hospital of within 24 hours a To the Funeral Completed filled is Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059633 ss of person who completed cause of death (Item 23a) (Type, Print) Jacob 1221 Mercantile Ln. Glen M. Largo, MD 20774 Date filed (Month, Day, Year, 32. Registrar's Signatur State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 U | U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9 <u>2010</u> Physician/ DECEMBER 4:00 P M GRAVES Medical ZINNIE 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S CAPITOL HEIGHTS 729 LARCHMONT AVENUE 8. Date of Birth (Month, Day, Dec. 9 5. Social Security Number 7. Age (In yrs. last birthday) 86 yrs. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 M 2 X F <sup>Year)</sup> 24 578-38-3754 NORTH\_CAROLINA Director Usual Residence of Decedent 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 √ Yes 2 □ No CAPITOL HEIGHTS MD PRINCE GEORGE'S ъ 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 729 LARCHMONT AVENUE 20743 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. , o. Armed Force Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give within 72 hours after 1 ☐ Yes 2 X No Specify: BLACK "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the PRIVATE 12 should be filed with and Mental Hygie 27 is marked other r traumatic event, the BEAUTICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ JOSEPHINE BUNN JOSEPH PERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27525permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 4223 WEST RIVER ROAD FRANKLINTON, NORTH CAROLINA KATHRYN P. PERRY/SISTER 20a. Method of Disposition
1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 12/17/2010 FRANKLIN, NORTH CAROLINA NELSON CHAPEL CEME. J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 Yes 2 XNo Dav 5 Other (specify) Pregnant at time of death g 🔲 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated bage 2 should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2X No 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 XN ours after death.

eral Director: After this certific filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 【XResidence 6 ☐ Other (Specify) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D completed filled in the filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗀 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who/completed cause of death (Item 23a) (Type, Print) SALVAdor 5 32. Registrar's Signature Garko Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

21215-0036

Baltimore, Maryland

68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DEC. **Physician** 2010 11:00A M Inez Gullette Glime /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline Caroline Nursing Home Denton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Apr. 4, Birthplace (State or Foreign Country) Funeral Days Hours Min. <sup>Year)</sup> 1924 Months 218-16-8129 86 Director Maryland Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Expriner fourth by nutflind at once. Caroline 1 □Yes 2 No Director MD Federalsburg 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21632 United States 4320 Smithville Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. þ Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sewing Seamstress 11 (Grad.) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Carl Gullette Mary Catherine Stafford ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph R. Glime/ Son 4130 Smithville Road, Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Junior Order Cemetery 12/15/10 Preston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee Muchael Ukow 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2 No g 
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed? 1 ☐ Yes To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO 12005325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Butos Avenue Preston MD Melinda 136 L 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 13 **Physician** 2010 December 4:45PM Michael Francis Goodman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Envoy of Denton Denton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | May 5, 1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 215-16-6962 89 May Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State ms 23a or 28a-f show must be notified at 1 X Yes 2 □ No Director Maryland Caroline Denton 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 904 Gay Street; Apt. 21629 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Argued Forces?
1 Pyes 2 □ No 1942
If Yes, Give
Year or Dates: to 1945 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: White Specify þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Municipal Government/ College (1-4or 5+) Elementary/Secondary (0-12) Baltimore City 10 Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Goodman Theresa Boracki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Heatth an
Important: If Item 27 Is I
any injury or other traus
once. Sharon Kleczynski/niece Butler Drive, Denton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Denton Cemetery Dec. 17,2010 | Denton, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Lice Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) artery **Physician** Coronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending above and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 3 ☐ Probably 4 ☐ Unknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 21 INO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 40 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To 27. Man or of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D005325 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) An Preston MD 136 lednun Butter Melinda

State Registrar 31. Date filed (Month, Day, Year)

DEC 16 2010

32 Registrar's Signature



Pox

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 13, 2010 Theurer Guidrey 5:00 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Montgomery Rockville Arbor Place Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 MA **Funeral** 8. Date of Birth Days 1 □ M 2**X** F Hours Sept. 25, <sup>7</sup>1915 Yrs Director 95 015-12-3291 Usual Residence of Decedent or 28a-f shov 10a, State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗆 Yes 2 🏲 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 17026 Barn Ridge Drive 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ould be filed within 72 hours after on Mental Hygiene.

marked other than "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 MNo Specify: 3 → Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) Mary Ann MacFarlane 17. Father's Name (First, Middle, Last) ည Otto Adolph Theurer should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i 17026 Barn Ridge Drive, Silver Spring, MD 20906 JoAnn G. Aulick/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) <sup>Jan</sup>11 4 Donation 5 Other (Specify) Arlington National Cemetery Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown P.O. as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 N this certificate 2 🗌 No 1 Yes Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Softer (Specify) Hospital: Other: 2 🔀 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending ithin 24 hours after death.

the Funeral Director: Aimpleted filled in by the fu 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the | within 2 To the f Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dec. 13, 2010 30. Name and address of person who completed cause of death/(tem 23a) (Type/Print) 3801 International Drive, #211, Silver Spring, MD 20906 N kul Goyal, MD

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December 10, 2010 Herman Gottesman 6:30P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hillhaven Assisted Lvg. Nursing & Rehab Center Adelphi Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. March28, 1913 183-03-3370 97 Pennsylvania Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Prince George's Director Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12009 Montague Drive 20708 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:1942-1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White <u>ک</u> 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Meonee. Elementary/Secondary (0-12) College (1-4or 5+) printing company Printer owner/operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Gottesman Augusta (unk) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Della J. Gottesman -daughter 12009 Montague Drive Laurel, Maryland 20708 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State Metropolitan Crematory 12/13/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Şervice Licensee Donald V. Borgwardt Funeral Home, PA LU 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Con estive Cardiac Failure one year /Medical Due to (or as a consequence of) Examiner Mitral Heart Disease ten years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Examine Atrial Fibrillation ten years Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia; Dysphagia; Dementia No 3 Probably 4 Unknown Completed 24a. Was an Was autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 1 Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

The law requires that the death certificate be executed as the burial ransit and Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria nse page 2 s this certificate Attending Physician: director, funeral To the Hospital or Attending Privithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

the Maryland

with

death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

Medical

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D17843

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

December 13, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vivek C. Vaid, M.D. 3311 Toledo Terrace, #B102 Hyattsville, Maryland 20782

State Registrar

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

**DEC** 14 2010



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-09521 2010 41424 State of Maryland / Department of Health and Mental Hygiene Jose Neptaly Molina-Giron Certificate of Death Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ 0155 hrs Jose Neptaly Giron-Molina December 11, 2010 Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly PG Hospital Center 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Foreign Country) **Honduras** Hours Min Months Days Director 1 X M 2 F 32 May 20, 1978 None Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No 28a-f show Hyattsville tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. within 72 hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5993 Arbor Street 20781 Honduras Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: White 1 Yes 2 No specify: Honduran 4 Divorced Give Year 3 Widowed <u>۾</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 77 is marked other than "n
injury or other transmite event, the Medical E. Elementary/Secondary (0-12) Construction 12 Superintendent 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Emilia Giron Palasios Fabian Molina Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ۵ 12 Filbert Court, Gaithersburg, MD 20879 Jose Fabian Molina /Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery. 20a. Method of Disposition crematory or other place) 1 XBunal 2 Cremation 3 X Removal from State Dec. 17, Jesus de Otoro, Intibuca, Cementerio Municipal Honduras Donation 5 Other Specify: 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Approximate Interval t I. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Gunshot Wound of Torso Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last sician/Medical UNPENDED AMENDED attending physician for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Fetal death 3 Ectopic pregnancy Month Year Live birth Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for Unknown signed by the a Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an this certificate has been prior to completion of cause of autopsy performed' death? ✓ Yes 2 No 2 No 1 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> Hospital: 1 Inpatient examiner? Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA 2 1 Yes ۵ 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Dec 10, 2010 Subject shot 2134 hrs Division Natural 1 Yes 2 ✔ No 5 Pending hours after death. within 24 hours after death To the Funeral Director: filled in by the 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 8613 Preston Street, New Carrollton, MD determined (Specify) yard 4 🗹 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie December 11, 2010 O.C.M.E. lorn 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) kegistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Da 134 Fruma Ginsburg Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth Funeral 9. Birthplace (State or Foreign Days NoWonth Pay, 1911 Hours Min 1 M 2 5 F Carthuania Director 216-46-0890 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director Gaithershurg 1 XYes 2 No MD Montgomery ō 10e, Street and Number 10g. Citizen of What Country? Funeral with items 23a 208 Park Avenue #611 20877 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2x No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Translator Library of Congress and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sermit. Page 1 and 2 should be fil.
Department of Health and Mental
Important. If item 27 is marked
any injury or other traumatic eve
once. ဂ္ Zunol Vartovsky Zlata Gerberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Park Avenue #611, Gaithersburg, Maryland 20877 Sandy Rosenblum/Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ➡ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) King David Mem. Grds | 12/10/2010 | Falls Church, Virginia Signature of Funeral Service Licensee 22. Name and Address of Fardward Sagel Funeral Direction, Inc MCG wenhul 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ neumoni disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine n any, leading to immediate cause. Enter Underlying Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause giren in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 📈 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 12706/2010 CALVIN CLIFTON GENIES 5:30 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 637 Blandford Street Rockville Montgomery . Social Security Number Sex 14 M 2 □ F If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign MD Country) Hours. Min. 08/27/1924 220-26-6225 Director 86 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 637 Blandford Street 20850 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 XMarried Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: 3 Divorced 4 Divorced Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8th Heavy Equipment Operator Construction permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, f Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Washington Genies Iucinda Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nohra Genies/wife 637 Blandford Street, Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) X Burial 2 ☐ Cremation 3 ☐ Removal from State of Heaven Cem. 12/13/10 4 Donation 5 Other (Specify) Gate Silver Spring, MD 21. Signature of Juneral Service Licens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 Enter the disease ons that caused the death. D or complic of enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only o Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a con if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or impury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 MResidence 6 Other (Specify) 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔏 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie completed cause of death (Item 23a) (Type, Print) 50, W. Edmonston Dr. # 504, Rockville, mi). 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 3:28 P<sup>M</sup> 22, 2010 Gwendolyn A. Geer December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** White Hall Harford 5318 Norrisville Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 🛛 F 89 Yrs. May 20, 1921 MD Director 212-12-1269 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It e Madical Experiment must be notified at 1 ☐ Yes 2 No Director White Hall MD Harford 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 5318 Norrisville Road 21161 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ifiled within 72 hours a Il Hygiene. other than "natural", c þ White 3 ☐ Widowed 4 🛱 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglen Important: If item 27 is marked other the any Injury or other traumatic event, Ital once. Construction Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amy Irene Norris ဥ Wilton W. Ashburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20015 Amy Stewart/Daughter 6124 33rd Street N.W. Washington D.C., 20b. Place of Disposition (Name of cemetery, crematory or other place, Cremation Direct Service 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 🛣 Removal from State 12/24/2010 York, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Signature of Funeral Service Licer PA 17363 19 South Main St. Stewartstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute weeks remal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Deh dre Min Due to (N as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed 8ancrest h5 physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? certificate 1 ☐Yes 2 ☑No Demenha After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 🖼 🔨 o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending Pin 24 hours after death.

Refuneral Director: After to betely filled in by the funera 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of Sperson who completed cause of death (Item 23a) (Type, Print) D31295 12/23/10

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State Registrar 31. Date filed (Month Day, Year)

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5 701 32. Registrar's Signature sei.

Bathmore mo

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ HARRY STUART GRANT, JR. 12:45 A<sup>M</sup> DEC 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner WASHINGTON WILLIAMSPORT WILLIAMSPORT NURSING HOME Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** ST VIRGINIA Months Hours 82 234-46-8103 Director 6/8/1928 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. aut: if ifew 272 is marked other than "natural", or items 23a or 28af sho aut: if item 272 is marked other than "natural", or items 23a or 28af sho ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 √ Yes 2 ☐ No WILLIAMSPORT MD WASHINGTON 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral USA 21795 154 N. ARTIZAN STREET 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) EDUCATION TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ABBIE TABLER HARRY S. GRANT, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16105 WRIGHT RD., WILLIAMS PORT, MD 21795 19a. Informant's Name/Relationship (Type, Print) MARY BROWN/NIECE permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State DEC. 23, SMITHSBURG, MD SMITHSBURG CREMATORY 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service License 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, MARTINSBURG, WV 25402 327 W. KING ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Smennion Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying death certificate be executed use as the burial-transi Cause (Disease or impury and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Day Month Year Yes 2 ☐ No 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by with Division of Vital Records, 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a. Was an autopsy Langestive performed' Heart Farhere 1 ☐ Yes 2 ☐ No Yes 2 No or Attending Physician: 25. Was case re erred to medical director. Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 📉 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the furieral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) cember 21, 2010 dress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State JAN 03 Registrar

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State of Maryland / Department of Health and Mental Hygiene 2 U | U For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ DEC. 15, 2010 6:50A M GEORGE ADDISON GRAY, JR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
PRINCE GEORGES **Examiner** PRINCE GEORGES MED. CENTER CHEVERLY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🙀 M 2 🗆 F Months Hours Min. 7 - 3 1 - 1 9 4 1 WASH., D.C. 577-54-8317 69 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10b. County filed within 72 hours after death with the Maryland Examiner must be notified at 10a, State Director . CHARLES MD. WALDORF 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country?  $U \cdot S \cdot A \cdot$ 9 10e Street and Number 23a ST.PAUL'S DRIVE 20602 Funeral 1040 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. 1 X Never Married 2 Married o. þ Yes 2X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. Specify: WHITE "natural" Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once." 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SALES PERSON SHOE STORES 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EVELYN RUTH NORTON GEORGE A. GRAY, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1040 ST.PAUL'S DRIVE WALDORF, MD. 20602 CHARLES GRAY-BROTHER Baltimore, 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State ATLANTIC CREMATORY 12-22-10 GLEN BURNIE, MD. 4 Donation 5 Other (Specify) of Funeral Service Lice M00479 MÖNGGERÜREKAL SERVICE, P.A. PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEVERE SEPSIS Physician/ disease or condition resulting in death) Medical Examiner RIKARY Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit METABOLIC ACIDOSU that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HUPERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? ARTERY CORUNARY \_\_ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital 1 🗌 Yes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Jak I Engure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Dec. 15<sup>Day</sup> 20 YU 9:18 Garner Cherv1 Lynn Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Prince Frederick Burnett-Calvert Hospice House Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗗 F Days Hours Min. A Day Year) 949 579-68-0496 61 Director D.C. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Calvert Dunkirk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral USA 20754 12185 Cavalier Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. à 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify: Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Presser Dry Cleaners Be other traumatic event, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic evem 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Myers Baker Inez Nei1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12185 Cavalier Drive Dunkirk, MD 20754 19a. Informant's Name/Relationship (Type, Print)
Gary M. Garner-husband 12185 Cavalier Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ches. Hilnds M.Cem 12/21/10 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Port Republic, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell1Funeral Home Gladen a. 1451 Dares Beach Rd. Pr. Fred., MD20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ metastatic nonsmall cell lung cancer disease or condition 7 marti Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Ves 2 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical B B 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☑ No |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Presidence 6 Nother (Specify) hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Pyes 2 No 1 Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) December 17 2010 1)56024 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Abbott Prince trederick 110 Hospital Road Sule 110 31. Date filed (Month, Day, Yes 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Susan Lee December 2010 7:40 P.M. Heeter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Center Prince Georges Clinton 9. Birthplace (State or Foreign If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Country)
Washington, D.C Days Min. (Month, Day, Year) 1 - M 2 - F 213-90-6355 Director 48 27, 1962 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director MD Prince Georges 1 Yes 2 No 28a-f Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 Funeral items 23a 5303 Salima Street 20735 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status ò 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White "natural", 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Receptionist Medical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental item 27 is marked ည John Leroy Heeter, Sr. Pearl Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl L. Heeter/ Mother 5303 Salima Street, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place)
Geo. Wash. University 20c. Location - City or Town, State 20a. Method of Disposition December 11 Page 1 permit. Page 1. Department of I 1 Burial 2 Cremation 3 Removal from State Washington, D.C. injury or 4 ☑ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service Lice /M00969 9013 Annapolis Road, Lanham., MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of ◆Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 1 Highway Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 24 hours after death.

Funeral Director: After this certificate has autopsy performed 1 🗌 Yes 2 🗆 No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Umpatient 2 ER/Outpatient 3 DOA မ 27. Manne eath 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 5 Pending Natural 1 🗌 Yes 2 🗌 No Investigation ☐ Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Configuration. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed within 2 To the F only one) 3 29b. Signature and of certifie Name and address of (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Carolyn Virginia Hollingsworth December 2010 11:50 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline Nursing Home Caroline Denton Funeral Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Maryland 1 □ M 2 □XF Months Days Hours Min. April 24, Director 216-38-7616 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked of other than "natural", or items 25a or 28a-f sho are injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Caroline Denton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 319 S. 4th Street 21629 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces 1 \( \text{Y} \) Yes 2 \( \text{Y} \) No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. þ 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 🗆 Widowed 4 🗆 Divorced Completed Specify. White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 HS Grad. College (1-4 or 5+) Secretary Trucking Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jefferson Wilson Cohee Winifred Paige Towers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Hollingsworth/spouse 319 S. 4th Street, Denton, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🗔 Burial 2 💢 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Capital Crematory Dec. 22, 2010 Dover, Delaware . Signature of Juneral Service Licenses 22. Name and Address of Facility Moore Funeral Home, P.A. South Second Street, Denton, Maryland 23a. Part 1. Enter the disease, o shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, that y leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for se's consequence on sician and burial-transit Exami the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown 1 ☐ Yes ∠ ₩ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform certificate 1 Tes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending work? within 24 hours after death.

To the Funeral Director. Aft
completed filled in by the fu 2 🗌 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3

30. Name and address of person

31. Date filed (Month, Day, Year)

22

only one 29b. Signature

Registrar DHMH 17 Rev 7/2009

State

egistrar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:55 PM 2010 James Leon Hodge December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clinton Southern Maryland Hospital Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 27, **Funeral** 9. Birthplace (State or Foreign Days 1**X**X M 2 □ F Hours **Director** Yrs Florida 264-32-7627 Usual Residence of Decedent f show 10a. State 10b. County "natural", or items 23a or 28a-f sho with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Prince Georges Maryland Brandywine 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14501 Duckett Rd. 20613 U.S.A Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 \( \overline{\text{D}} \) Yes 2 \( \overline{\text{D}} \) No \( \overline{1948} \)

If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Completed 1970 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Aircraft Maintenance Inspector U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Sidney Hodge Ruby Woodham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14501 Duckett Road, Brandywine, Maryland 20613 Keith Hodge (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important; If any injury or Donation 5 Other (Specify) Maryland Veterans Cemetery Dec 22, 2010 Cheltenham, MD ure of Funeral Service Licen Sign moisis 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No Director: After this certificate 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide within 24 hours after To the Funeral Direct Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title who completed cause of death (Item 23a) (Type Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

5

RBS+

Registrar's Signature

PISCATAUVA

10-09455 David Hensel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Arthur Hensel Month Day December 8, 2010 2314 hrs David Medical Examiner 4c County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 1609 Golden Chelsea Way 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number Funeral Months Davs Hours Dec.1,1962 Maryland 215-84-5805 48 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No Anne Arundel Jessup Marvland 28a-f show ages I and 2 should be filed within 72 hours after death with the Maryland and of Health and Mental Hygiene.

11: If item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at occa. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20794 United States 1609 Golden Chelsea Way 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes 1 Yes 2 No specify: White 4 X Divorced If Yes, Give Year Specify <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) transportation **Baltimore**, MD 21215-0036 Truck Driver 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Irene Beffa Richard T. Hensel æ 19a, Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ 11621 New Hampshire Avenue Silver Spring, MD20904 Irene B. Hensel -mother 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State 12/13/2010 Laurel, Maryland Ivy Hill Cemetery rtant: 4 Donation 5 Other Specify: Donald V. Borgwardt Funeral Home, 21. Signature of Funeral Service Licenses UK 4400 Powder Mill Road Beltsville, Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and ( certificate be executed sician/Medical attending physician for use as the burial -UNPENDED AMENDED of Vital Records, P.O. Box 68760, 23d, Date of delivery IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown icate has been signed by the ati page 2 should be detached for Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 1 Yes 2 ✓ No 3 Probably 4 Unknown pleted 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? COM ✓ Yes 2 No 2 No certificate 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Atteoding Physician: within 24 hours after death. Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene DOA 2 ER/Outpatient 3 After this 1 Yes No မှ 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Subject shot self FOUND: Natural 1 Yes 2 ✔ No Division 5 Pending To the Funeral Director: the Certificati 2250 hrs Dec 8, 2010 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 1609 Golden Chelsea Way, Jessup, MD determined (Specify) Single Family Home 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1C O.C.M.E. December 9, 2010 Marssel 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD 31. Date filed (Month, Day, Year) . Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

10-09782		Please Type or Print in Black Inde			ble.	1.11.25
Maximilian Alexa			ment of Health and Mental Hy	/giene	2010	11400
		Registrar	ficate of Death	Reg. 2. Date of Death		3. Time of Death
Physicia Medical Examir	-	1. Decedent's Name (First, Middle,Last)  Maximilian Alexander	. Halidau		av Year	1748 hrs
Medical Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	December	4c. County of Death	
		Holy Cross Hospital	Silver Spring		Montgomery	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24Hrs.	8. Date of 8 inth (	MM/DD/YYYY) 9. Birth	
Director		220-87-4510 1XM 2DF	Yrs. 5 21 Hours Min.	June 28	Foreigr 2010 Cou	ntry)Maryland
	-	Usual Residence of Decedent		June 20		
any.	ı	10a. State 10b. County 10c. City, To	wn or Location			10d. Inside City Limits
spow		Maryland Montgomery	Silver Spr			1 Yes 2 X No
Aaryla 28a-f	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Count	ry?
FSD r death with the Maryland or items 23a or 28a-f sho must be notified at once	ਙੋ	9727 Mt. Pisgah Road, Apt. #1401	20903		u.s	
with with	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>		14. Race - Americ White, etc.	an Indian, Black,
or ite	뒨	Never Married 2 Married 1 Yes 2 X No			Consitu	Other
ral",	2	3 Widowed 4 Divorced of Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16	1 Yes 2 X No specify:  Sa. Decedent's Usual Occupation (Give kind of w	vork done	Specify: 6b. Kind of Business/In	
hour hour		Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retir			,
36 hin 72 than	휣	0	N/A		N/	4
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Ma		
215-0036 be filed within 7 mtal Hygiene riked other than	Be	Justin A. Holiday  19a. Informant's Name/Relationship (Type, Print )		Sophie	J. Le	
1D 21215 2 should be file 1 and Mental H 27 is marked of matic event, it	리		19b. Mailing Address (Street and Number or R			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahinjury or other traumatic event, the Medical Examiner must be notified at once	- [	Justin A. Holiday - Father	9727 Mt. Pisgah Rd.,	#1401, S	ilver Spri	ng, MUZ0904
nore, ages 1 an nt of Hea at: If ite		1 8urial 2 Y Cremation 3 Removal from State crer	matory or other place)			
Page nent o		4 h ponation 5 to Other Specify:	Lincoln Crematory 12,	/27/2010	Brentwood,	Maryland_
Baltimore, permit. Pages I an Department of Hea Important: Titee		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hin	es-Rinal	di Funeral	Home, Inc.
	_	266. Part I. Enter the disease, or complications that caused the death. Do	11800 New Hampshire	respiratory arrest	shock or heart	Approximate Interval
Physician /Medical		failure. List only one cause on each line.	o not one of the mode of cyling, coals, are called a	, , , ,	- Carlot and All Control	8etween Onset and Death
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	ner	if any, leading to immediate cause. Enter Underlying Cause				
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and and transit		d				
ਲ ਸ਼ਾਜ਼	dical	x unpended Amended 23a,27,2	8a-f per me g912 2-28-	-ll vt		
Box 68760, the death certificate be eath catting physicial the attending physicial ted for use as the buria	Medi	IF FEMALE: 23c. If yes, outcome of pregnar			23d. Date of delivery	av Year
687 certifi nding se as t	ian	past 12 months?	2 Fetal death 3 Ectopic pregna 5 Other (Specify)	ncy	Month Da	iy teal
Sox leath e atter	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	Other (apeciny)			
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f, P.O. ires that the signed by the detache	ğ			1 Yes	2 No 3 Proba	ibly 4 Unknown
cords, faw require has been s	pleted			24a, Was an autopsy		opsy findings available impletion of cause of
e faw	Comp			performe 1 ✓ Yes 2		2 No
Vital Rec ysician: The ! his certificate !	ပ္	25. Was case referred to medical	26.Place of Death (Check of	only one)		
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Sion Atteodi r death.	atio	2   X   Accident   Investigation	d 5:00pm 1 Yes 2 X No	plastic	"chux"	
or At after of Direc	Certification	3 Suicide 6 Could not be 28e. Place of Injury - At home	e, farm, street, factory, office building, etc.	28f. Location (Street or Town, State	eet and Number of Rurs se) 9/2/ Mt. Silver Sp	Pisgah Rd.
Spital spital spital spital	ဦ	4 Homicide determined (Specify) resid				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.		29a. Certifier (Check only one)  Quantifier 1 Certifying Physician: 76 the best of my knowledge, one)  Wedical Examiner: On the basis of examination and/	death occurred at the time, date and place, and for investigation, in my opinion, death occurred a	due to the cause(s t the time, date an	s) and manner as stated diplace, and due to the	cause(s)
To the To the comp	Medical	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	
	-	/ / //	O.C.M.E.	1	December 19, 20	10
		30. Name and address of person who completed cause of death (Item 23	3a)			
DOMÉ		Mary G. Ripple MD. Deputy Chief Medical Examin		D 21201		
Sta	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	barber,			
Regist	rar	DEC 27 2010 Sever A.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2010 11:45 p December Warren Hester Sr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Heartland of Hyattsville Nursing Hme Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Virginia **Funeral** (Month, Day, Year) ec. 12, 1922 Min Months Days Hours 1 🛛 M 2 🗆 F Dec. 578-20-1987 87 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---- any injury or other terms." 10b. County 10a. State Director 1 X Yes 2 No Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 20017 1314 Michigan Avenue NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?
1 X Yes 2 □ No þ 1 Never Married 2 Married **Black** 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Government Cartographer 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Louise Parks William Hughes Hester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 1314 Michigan Avenue NE Washington, DC Betty Hester - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a, Method of Disposition December 2010 cemetery crematory or other place)
Maryland
National Cemetery 1 X Burial 2 Cremation 3 Removal from State Laurel, Maryland ☐ Donation 5 ☐ Other (Specify) nature of Funeral Service Licens 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Si 20019 200 4001 Benning Road NE Washington, 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury Cancer of the Prostate and that initiated events Due to (or as a consequence of) resulting in death) Last attending physiclar Physician/Medical Cancer of the Lungs P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery nse 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) for Pregnant at time of death 2 🗌 No detached Unknown the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed Completed by 1 Tes 2 No 3 Probably 4 M Unknown should be Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 s has performed' 1 ☐ Yes 2 ☐ No Yes 2 X No certificate 26. Place of Death (Check only one) Division of Vital or Attending Physician: 25. Was case referred to medical funeral director, Be Other: 4 X Nursing Home 5 A Residence 6 A Other (Specify) examiner' Hospital 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes မှ this , or Afte.
.s after death.
ral Director: After th' 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29c. License number title of certifie 29b. Signature D46529 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20770 7325A Handover Parkway Greenbelt, Maryland

Registrar
DHMH 17 Rev 7/2009

State

Victor Onyejiaka
31. Date filed (Month, Day, Year)

DEC 1 6 2010

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 U 1 U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dec. Physician/ 13 20Î0 12:05 A M John W. Herring Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall 9. Birthplace (State or Foreign 8. Date of Birth

(Month, Day, Year)

Dec. 7, 1924 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 1 🛛 M 2 🗆 F Pennsylvania 86 Director 219-20-1706 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director Baltimore 1 Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 21214 USA 6614 Fair Oaks Ave. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. Armed Forces Completed by 1 Never Married 2 Married X Yes Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates. 1943-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene tant; If item 27 is marked other than 'iury or other traumatic event, the Me iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Construction Craftsman 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Mabel Miller Dory Herring 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6614 Fair Oaks Ave., Baltimore, MD 21214 19a. Informant's Name/Relationship (Type, Print) Sheirazada J. Mutreja, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 Removal from State Oak Lawn Mem Gardens 12-23-2010 Gettysburg, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License 12525 Bradbury Ave. Davis Funeral Home Smithsburg, MD 21783 23a. Part Debuthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZHEIMER'S DEMENTIA Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of) if any leading to immedicause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Be Completed ESSENTIAL HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check ₃ □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of centifier MD DO067788 unleed 20.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAO KODA 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Decembe 2010 <u>Ileda</u> Medical Grace House 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min (Month, Day, Yea /12/192 Country)
Maryland **Director** 215-20-8831 Usual Residence of Decedent 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at. 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Marvland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral West Wilson Blvd U.S.A. within 72 hours after death Was Deceus Armed Forces?, Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates. Specify: Specify 3 Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Kitchen Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hubert Rowland Reeder Tsabe1 C. Martz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a ant: If item 27 is Connie House/ Daughter 38 Redwood Dr. Hagerstown, Maryland 21740 other i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Haven Cemetery | 12/22/2010 | Hagerstown, Maryland 21. Signature of Funeral Seprine Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 2 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician IE C GRÓBROUASCULAR Medical resulting in death) Due to (or as a consequence of): Examiner ATRIAL FIBRIL Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to for as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury 7 PORTOUSION use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical LEU COCTIOSI Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Month 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 🗌 No ☐ Accident Investigation after death 6 Could not be thin 24 hours after de the Funeral Directo mpleted filled in by tl 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 3 🗀 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10062006 20/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene		

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Physic		Decedent's Name (First, Middle,Last)		Reg. No.  2. Date of Death  Month	3. Time of Death
Medical Exam	ine	- Talley large somes		Month Day Year December 13, 2010	1252 hrs
		4a. Facility Name ∦if not institution, give street and number)  Laurel Regional Hospital	4b. City, Town, or Location of Death Laurel	1 4c. County of Dea Prince Georg	
Funera		Social Security Number 6. Sex 7. Age (In yrs. last birl			
Director		231 - 41 - 85 26 1 M 2 F 25	Yrs. Months Days Hours Min	<b>→</b> 1 € 400 € 1 €	Country)
*u*		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
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Mary Mary	Te Te	10e. Street and Number	10f, Zip Code	10g. Citizen of What Co	ountry?
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ath wi	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S.  1 Never Married 2 Married Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>		erican Indian, Black,
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21215-0036 und be filed within 7 Mental Hygiene. marked other than	Bec	Donnie Jones	Mod icc	(First, Middle, Maiden Surname)	
212 ould b I Meni	P	19a. Informant's Name/Relationship (Type, Print )	b. Mailing Address (Street and Number or F	A TEFAUESON Rural Route Number, City or Town, Sta	ite, Zip Code)
e, MD 1 and 2 sho Health and item 27 is		Melissa Jones / Mother 113	23 Card Lane Po	itsmouth, VA ?	13701
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Mantal Hygiene.  The filem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.			of Disposition (Name of cemetery, ory or other place)	Date 20c. Location - City of	or Town, State
E 4 9 4 5	1	4 Donation 5 Other Specify: Chesa	neke Crematory 12/	16/2010 Beltsville	Maryland
Baltin permit. I Departm Imports		21. Si, ture of Fune/al Se Licensee	22. Name and Address of Facility Ete	^ =	Service
Physician		23a. Part I. Enter the disease, or implications that caused the death. Do no failure. List only one cause meach line. Cardiac Arry	t enter the mode of dying, such as cardiac or	respiratory arrest, show or he rt	Approximate Interval
/Medical :xaminer		failure. List only one cause meach line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	ythmia Associated Wi tery Origin And Sick	th Anomalous le Cell Trait	Between Onset and Death
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ion of Vital Records, P.O. Box 68760, reduing Physician: The law requires that the death certificate be executed teath.  tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit	Medical E	d.  IX UNPENDED IX AMENDED 23a,27 per	me g912 2-4-11 vt		
'60, ate be ohysici ne buri	Med	X UNPENDED  AMENDED 23a,27 per 8 per fh 9  IF FEMALE: 23c. If yes, outcome of pregnancy	913 3-15-11 vt	23d. Date of delive	TV
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30X death c e atten for us	Physician/	1 Yes 2 No 9 Unknown Pregnant at time of death 5	Other (Specify)		
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F, P.O. ires that the signed by	d b			1 Yes 2 No 3 Pro	obabiy 4 🗹 Unknown
Division of Vital Records, tal or Attending Physician: The law requires after death.  al Director: After this certificate has been sied in by the funeral director, page 2 should be	Completed				utopsy findings available completion of cause of
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n of ading Pl	ü	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. T	ime of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
00 4 2 8 2	icat	2 Accident Investigation 28e Place of Injury - At home far		28f. Location (Street and Number or R	ural Route Number City
Divis spital or At hours after d ineral Direc y filled in by	Certification:	4 Homicide determined (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	or Town, State)	arar reade rambor, only
Divi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal	th occurred at the time, date and place, and	due to the cause(s) and manner as sta	ted.
To the Hospital of within 24 hours at To the Funeral Drompletely filled	Medical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.			
	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	
		hy hi mis	O.C.M.E.	December 14, 2	010
		Name and address of person who completed cause of death (Item 23a)     Ling Li, MD    Assistant Medical Examiner	Street, Baltimore. MD 21201		
S	ate				
Regis	rar	31. Date filed (Month, Day, Year)  DEC 2 0 2010 Queen 9. Sauke			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year James **Physician** Dawn Denise 2245 M 12 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Memorial Hospital Easton taston MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours Min. 25, Director 1955 216-68-9514 Apr. Annapolis MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination must be notified at 1□Yes 2□No Director MD Caroline <u>Greensboro</u> 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 305 Church St. 21639 US Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? 1 ∐Yes 2x ☐ No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ William Oliver Dorothy Hiebler Nee Humphreys 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David E. James, Sr./Husband 305 Church St., Greensboro, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Cremation Dec. 22,2010 Chester, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility of Funeral Service Licenses Fleegle and Helfenbein Funeral Home, PA Box 160, Greensboro, MD 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Eplepticus Stalus **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ver kalemia Sequentially list conditions, it any leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Exami burial-tran and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Hepatic Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ ICI MYC disord er 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 ₽No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural 124 hours after death. e Funeral Director: Aft eletely filled in by the fur 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) KMohan MD D0069567 Dec, 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rava Mohan, 219 S. Washington St., Easton, MD 21601 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 22 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Margie Lee Jacobs 11:50 PM 12, December 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Transitions Health Care Sykesville Carrol1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) Months 234-44-3537 1 ☐ M 2 🖾 F Days Hours 80 Yrs Director March 1, 1930 Clarksburg, WV Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Director Maryland Carrol1 1 ☐ Yes 2 No Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ō 23a 3820 Akers Drive 21771 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🖾 No \$ Specify: White 3 Widowed 4 Divorced "natural" Completed d other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Washington Elementary/Secondary (0-12) College (1-4or 5+) Director of Medical Records 12 Adventist Hospital 7 is marked other traumatic event, if 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Samuel Dean Ruby Shock ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Robert G. Jacobs / Husband 3820 Akers Drive, Mount Airy, MD 21771 Department of Health Important: If Item 27 any Injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 12/17/2010 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue 9 Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician harusc (can) /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events coulding be death). Examine Due to (or as a consequence of). law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached f 5 Other (specify) 1 Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ cate has been signated by page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Division of Vital 2 🗆 No 1 □ Yes 2 □ 1√0 1 ☐ Yes e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | ₩15 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one within 2 and manner stated the

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31. Date filed (Month, Day, Year) Registrar 7 ZUIU

29b. Signature and title of certifier

32. Registrar's Signature parke

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ahmoud

d

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item of Maryland Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Krulik 2010 0046 Medical Gloria November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Suburban Hospital</u> <u>Bethesda</u> <u>Montgomerv</u> 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs. 8. Date of Birth 077-22-4118 1 🗆 M 2 💢 F Months Days (Month, Day, Year) 2/29/1926 Director Yrs 83 New York Usual Residence of Decedent and Mental Hygiene.
r is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No NY Kings <u>Brooklyn</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1217 East 28th Street 11210 and 2 should be filed within 72 hours after death wealth and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Guidance Counselor Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Samuel Ancell Thelma Lerner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11007 Cedarwood Drive
1007 Cedarwood Dr. Rockville, MD 20852 permit. Page 1 and 2 st Department of Health a Important: If item 27 is <u>Eleanor Levitt / Daughter</u> or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 11/30/2010 <u>Judah</u> Cemetery Ridgewood New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO1477 Danzansky-Goldberg M 1170 Rockville Pike Memorial Chapels Inc. Rockville, MD 20852 <u>Blake</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Acute Myocardial Infarction Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) g physician and as the burial-transity or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl for use as t IF FEMALE: . nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? Yes 2 No death? 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 1 Yes 잍 1 Inpatient 2 K ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D54776 December 8, 2010 ss of person who completed cause of death (Item 23a) (Type, Print) Barton Lebnard, 8600 Old Georgetown Rd. Bethesda, MD 20814 M.D31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

		For 1 - State Registrar	Sta	ate of I	Marylan		artment o rtificate		alth and eath	Mental	Hygie Reg.	11-01	10	4144
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, -		30. Name and address of per	rson who complet	ed cause of	of death (Item	23a) (Type:	Print)					10,	201	
		Robert Blee,	•	5530 1	Wiscon	sin Av	e. #1	400 -	Chevy	Chase	. Md	2081	5	
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Registra	ar	DEC 1	4 2010	Censu	a p	. 190								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10-09800 Michael Kronstadt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 4155 State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar		Cert	ificate of	Death		Re	g. No.	
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene, ten 27 is marked other than "natural", or items 23s or 28s-fah traumatic event, the Medical Examiner must be notified at once		Allen R. Krons	tadt – Fa	ther	10201	Grosveno	r Place,			
ш . ж		20a. Method of Disposition			ace of Disposit	tion (Name of ceme	etery,	Date	20c. Location -	City or Town, State
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Baltimore, permit. Pages I an Department of He Important: If ite injury or ather tr		4 Donation 5 Other S		Jua	ean men	n. Garaen	15   12/2	22/2010	veney,	Maryland
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m godie	$\perp$	- LINCHURCH II.V	YUXU	401241	1118	00 New H	ampshire	ave.,	Silver:	Spring, MD20904
Physician	1	23a. Part . Enter the disease, or failure. List only one cause		caused the death. [	Do not enter th	e mode of dying, s	uch as cardiac or	respiratory arre	est, shock, or hea	rt Approximate Interval Between Onset and
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£xaminer		or condition resulting in death)		a consequence of):		<del>-</del>	·		<del></del>	
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8760, ifficate be ng physic is the burn	활	IF FEMALE:	23c If yes	outcome of pregna	ency				23d. Date of	delivery
876 iffica ng ph	≥  2	23b. Was decedent pregnant in the		birth	2 Fet	al death 3	Ectopic pregnar	ncy	Month	Day Year
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/is driver of the rest of the	<u>₽</u>		ld not be 28e. Pla	ce of Injury - At hor	me, farm, stree	t, factory, office bu	ilding, etc.	28f. Location (\$	Street and Number	er or Rural Route Number, City
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Division of Vital Records, P.O. Box 68760,  To the Hospital noticate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiti	악	29a. Certifier	hysician: To the be	st of mv knowledge	e, death occurr	red at the time. date				
the F in 2, the F	<u>  8</u>	(Check only	miner:On the basis							
To To Com	Medical	29b. Signature and title of certific	and manner			29c. License				ed (Month, Day, Year)
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	}	11/1/1	1		10	0.C.M	1.⊂.		December	20, 2010
	ŀ	30. Name and address of person	who completed cau	use of death (Item 2	23a)	+				
		Russell Alexander MD	D. Assistant I	Medical Exami	iner 111	Penn Street, 8	Baltimore, MI	D 21201		
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Sta	te.	31. Date filed (Month, Day Year)	2010	legistrar's Signatuh	e A	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ann Louise Kehoe 10:00 AM 2010 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12602 Hillmeade Station Drive Prince George's Bowie 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye October 9, 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 F Hours Min. 074-48-3043 52 National City, CA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Prince George's 1 🗆 Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12602 Hillmeade Station Drive 20720 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 X Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry ant of Health and Mental Hygiene it if item 27 is marked other than "n. or other traumatic event. \*\*\* (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o Elizabeth M. Murphy James W. Kehoe, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Kehoe, Jr. Father 6911 Heidelburg Road, Lanham, MD 20706 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 12/16/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Metastatic pancreas cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown detached 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? 2 🔀 No 1 ☐ Yes 2 ☐ No pleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\boxtimes$  Residence 6  $\square$  Other (Specify) 2 🔀 No P 1 Inpatient 2 I ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending death. 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident 24 hours after deat Funeral Director: Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20066507 HYSICIAN MID DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Naimish Pandya, MD 22 S. Greene Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) **DEC 1** 7 2010 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2:12P 20, 2010 December Kendle Marie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington <u>Hagers</u>town 529 Chestnut St. If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 □ M 2 😿 F Maryland 9/30/1927 Director 83 212-24-3654 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number with 1 U.S.A. Funeral 529 Chestnut St. 21740 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 11. Marital Status Black White etc. hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) e filed within a all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be s 1 and 2 should be fill f Health and Mental H tem 27 Is marked ot John Wesley Crawford Blanche Edna Miller ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) / Husband 529 Chestnut St. Hagerstown, Maryland 21740 Preston M. Kendle, Jr. permit. Pages 1 am Department of Heals Important: If Item 2: any Injury or other 1 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/27/10 Hagerstown, Maryland Rest Haven Cemetery 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) an ( /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical as ding use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death atten for us 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Do of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 \sum Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) Certification: To After this 27. Manner of Leath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State Registrar

(Check only

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

2

29c. License numbe

and manner stated

32. Registrar's

30

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ <u>December</u> 2010 7:26 P. <sup>™</sup> Albert Vaden Kitts Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Emmitsburg 17250 Annandale Rd If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min. 1 □**X**M 2 □ F Days Hours Country) 63 **Director** 214-46-5128 1947 Mary Tand Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐XNo Frederick Emmitsburg Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21727 U.S.A 17250 Annandale Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced Yes 2 No þ Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify: Completed Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenace College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lula E. Whisman Albert V. Kitts Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annandale Rd. Emmitsburg, Md. 21727 Charlotte V. Sullivan(Companion 17250 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dec. 26, Smithsburg Crematory Smithsburg,Md. 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. M01414 Davis Funeral Home Smithsburg, Md. 21783 J.L. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line nterval Between 2)set and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) momous MIE Medical Due g (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequinor of signed by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 Pregnant : 9 Unknown Pregnant at time of death completed filled in by the funeral director, page 2 should be detached 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a Was an has autopsy performed?

1 Yes 2 No death? Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No Be 25. Was case referre to examiner? medical 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, 00 18705 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Pri Emmitsburg S. Seron 310 arroll 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 03

3 DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ 2:05 PM May Lytton 07 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital  ${ t Clinton}$ Prince George's If Under 1 Year g. Birthplace (State or Foreign If Under 24 Hrs. Social Security Number 6. Sex Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) Country)
Jamaica 1 M 2 X 8 578-52-7062 94 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD Prince George's Temple Hills 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 6706 Northam Road 20748 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. Black þ 1 Never Married 2 Married 1 ☐ Yes 2 🔣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify Specify 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Clerk DC Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Unknown Rebecca Wisdom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Gardner/Daughter 6706 Northam Road Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Md Gate of Heaven 12/15/2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to mimediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Month Day Year 5 Other (specify) Pregnant at time of death signed by the and be detached for 1 ☐ Yes ≥ ₽ a 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 1 Yes 2 No Yes 2 No this certificate **Division of Vital** 25. Was case referred to predical examiner? 26. Place of Death (Check only one) director, Be Other: 1 🗌 Yes ER/Outpatient 3 DOA မြ 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Matural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fune. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the unite, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier TARALL REDDY, 0 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 10, 2010 10:00 P M Norma Ray LEVY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Nursing Home Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Self Ork New Year 1931 9. Birthplace (State New York) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 K 103-28-6555 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Rockville Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 United States 14112 Canterbury Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white Ş Q 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Gampel Abraham Gampel 19a. Informant's Name/Relationship (Type. Print)
Tina Bridge, Daughter 19b Mailing Address (Street and Number of Rural Route Number City of Town, State Zip Code) 14107 Forest Ridge Drive, N. Potomac, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) <u>Judean Memorial Gardens 12/13/10</u> Olney, MD 21. Signature of Fune of Service Licensee Forch insky sterrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, it heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypertersion /Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lieuwe or in juny) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Bladder Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 2 No 217No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Eccutifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARMA, M.D. 743

Summer

32. Digistrar's Signature

D0064624

Walk Dr. Gaithesture

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George Ellwood Lamphere 2010 11:00 AM December 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death Montgomery Arden Courts of Kensington Kensington If Under 1 Year | If Under 24 Hrs. Funeral Social Security Number 6 Sex Age (In yrs. last birthday 79 Yrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, 160-26-6002 1 🕅 M 2 🗆 F Director Pennsvlvania Jsual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Montgomery Bethesda 1 X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 20816 United States 4986 Sentinel Drive #104 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1955-Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 1956 Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) President Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alveina Elizabeth Moore Frank Elmer Lamphere 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4986 Sentinel Dr. #104 Bethesda, MD 20816 Jean Lamphere / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 D Burial 2 A Cremation 3 Removal from State 12/13/2010 Falls Church, VA 4 Donation 5 Qther (Specify) National Crematory Signature of Funeral 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washignton, DC 20016 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate
Interval Between
Onset and Death
Years Immediate Cause (Final Physician/ disease or condition resulting in death) Alzheimer's Dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the Fried of the Cause (Disease or linjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 1 Yes 2 9 Unknown ed by the a 9 Unknown Division of Vital Records, P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 X No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Hospital or Attending Physician: The certificate 1 Yes 2 No Yes 2X N To the Hospital or Attending Pnysician. within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗓 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar

29b. Signat

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Cullen MD 7624 Wisconsin Ave.,

72. Registrar's Signature

29c. License number

D40216

#101 Bethesda, MD

29d. Date signed (Month, Day, Year)

12/13/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - For State Ammended Box #17 Per F.D WSH Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death December Physician/ 2010 10:00 a M James Robert Langdon, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Golden Living Center Westminster 8. Date of Birth (Month, Day, Oct 26, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 🗆 F Months Day, Year) 6 - 1919 Mary land 91 218-09-3642 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a, State the Maryland 10c. City. Town or Location Director ms 23a or 28a-f s must be notified Westminster 1 Yes 2 No Maryland Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21157 Funeral 724 Winchester Drive USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 'n, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white "natural", Completed 3 Widowed 4 Divorced WWII other than "natu ent, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Money. Gas Station Owner/Operator 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lula Etzler Joseph A. Langdon James A. Langdon -19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1749 Old Westminster Pike, Westminster, MD 21157 James R. Langdon II, son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 12/16/2010 Union Bridge, MD Pipe Creek Cemetery Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions Examine cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last physician at the burial-t Be Completed by Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) signed by the a ld be detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has ball director, page 2 s<sup>1</sup> autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital 1 ☐ Yes 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending e הספרו מון 24 hours after ספבה... the **Funeral Director: Aft** יבווסל in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat d address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Estella June Little 7:15 FM 2010 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 2005 de 100 Security Number 8. Date of Birth (Month, Day, Year May 28, 1 **Funeral** Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 □X Hours Country) MD Director 218-26-5335 Yrs May\_ Ĩ928 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Harford 1 Yes 2 No Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 147 Maulsby Avenue 21014 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 x No Specify 3 XWidowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than \* life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Day Care Provider Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Earl Thomas Adams Hassie May Mink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Ralph E. Little, Jr. (Son) 69 Dixon Avenue Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place) 1 🗆 XBurial 2 🗆 Cremation 3 🗆 Removal from State Evergreen Mem. Garden 12/8/2010 4 ☐ Donation 5 ☐ Other (Specify) Finksburg, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service License MO0764 PO Box 195 Sykesville, MD 21784 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cau Interval Between Onset and Death 7 Number Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical memi Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 W No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day ate has been signed by the page 2 should be detached 9 Unknown Jivision of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 🗆 No 1 Tes funeral director, Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **N**O Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending iniury work? Accident 2 | No within 24 hours after death To the Funeral Director: / completed filled in by the f Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 5099W 10 WJL W.O 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) HAVRE de GRACE 31. Date filed (Month, Day, Year) State DEC 1 Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Physician/ 12 Month 4:52 P M 10 2010 Joseph Martin Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In vrs. last hirthday) 9. Birthplace (State or Foreign **Funeral** Days Min 06/03/1920 Country) Maryland 1 M 2 D F Director 578-18-1627 90 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's **Bowie** YXX Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3850 Enfield Chase Court apt.#203 20716 USA 12. Was Decedent Ever in U.S. 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, er than "natural", or iter the Medical Examiner Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2xxNo If Yes, Give Maryland 21215-0036 Black 1 Yes 2XXNo Specify: Specify: 3 ₩ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Navy Elementary/Seconday (0-12) College (1-4 or 5+) years Accountant 17. Father's Name (First, Middle, Last) snould be file th and Mental Hy 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph M. Martin Isabel Daughtry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Adrienne Martin/Daughter 1155 Joyceton Dr., Upper Marlboro, MD 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 Cremation 3 🗍 Removal from State Metropolitan Crematory 12/11/2010Alexandria, VA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home Freak 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
WILKS Immediate Cause (Final Physician/ They movia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or impury Due to (or as a consequence of) death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Dav Pregnant at time of death Yes 2 No signed by the a d be detached f 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒No 24a. Was an page 2 autopsy performed? Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28c. Injury at work? 1 □ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending Natural iniurv 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun Division 2 🗌 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, reid Bah, My D46052 12/10/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway achapolis, MD Siona Bech, MD 31. Date filed (Month, Day, Year) **DEC 1** 5 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Dec 12. Physician/ Marks 2010 Marie 10:50 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3801 Hemlock Place Temple Hills Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days Hours Min. Aug 27. 1924 1 □ M 2 😾 F Washington DC 577 26 1539 Director 86 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 🔭 No Maryland 1 4 1 Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3801 Hemlock Place 20748 United States ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2XX No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2XX No Specify: Specify: White "natural", 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Homemaker Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ be Harold Reiger Minnie Schwalenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Tanenbaum (Daughter) 11113 Potomac Crest Drive, Potomac, MD 20854 item 2 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or of cemetery, crematory or other place) 1 Durial 2 XXCremation 3 Demoval from State 4 ☐ Donation 5 ☐ Other (Specify) Dec 15, 2010 Lee Crematory Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service modas7 Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🏋 No
9 ☐ Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 2 🗓 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 XX Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Noise Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) Dec 13, 2010 DOOJ1194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State

Registrar

XB2

32. Registrar's Signature

ERRUM

5801 Allentown Road, Camp Springs, MD 20748

Cornell Emmerson, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death 2. Date of Death 3. Time of Death Physician/ MASON 0834PM KELLU Alfredia 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death OF MARYLAND MEDILAL SYTTEM M BAUTIME 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) High Point, NC 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, **Funeral** 1 M 2 K Director show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director White Plains 1 🗌 Yes 2 🖵 No Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10928 West Point Place 20695 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 X Never Married 2 Married 1 Yes 2 WNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Specify: Black. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Kellie Mason, Sr. Icy Bell Duff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna M. Mason - Sister 2112 Racquet Place, Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dec 18,2010 Resurrection Cemetery Clinton, MD 22. Name and Address of Facility Signature of Funeral Service Licenses Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, of complicat shock, or heart failure. List only one ca ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. INFILTRATION METASTASIS disease or condition Medical resulting in death) Examiner Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner sician and burial-transit **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ate has been signed by the atte page 2 should be detached for Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PORIPHONAL NEVED PATHY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? SACRAL PREJSVAE 24a. Was an 24 hours after death.

Funeral Director: After this certificate has perform 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time. Date and place, and due to the ease (e) and manner as stated 29b. Signature and title of certifier AV4176435619653 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NB5 MICHALI GHERTE ST PAUT, MD 2/20 22 500 TH 31. Date filed (Month 32. gistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ DECEMBER 9:55 ΑM REBECCA LOUISE MCKENZIE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Oct. 28 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 1 □ M 2√□ F 219-14-8503 Oct. 85 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at anone. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County Director 1 Yes 2 No Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 5681 Pebble Drive 21703 U.S.A. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc ☐ Yes 2 🗓 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Specify: 3 XWidowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Co-Owner & Operator Nursery 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah Elizabeth Nusbaum Calvin Edward Boone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bob Basham / Son-in-law 5681 Pebble Drive, Frederick, MD 21703 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 12/18/2010 Libertytown, Maryland Union Chapel Cem. 21. Signature of Funeral S lice Licens ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. Kult 1201 NORTH MARKET STREET, FREDERICK, 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ VAscelan YEARS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Febrallatio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>a</u> 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work?
1 Yes 2 No Natural Accident iniury 5  $\square$  Pending Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frerma NO 2124 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 76, 2010 Physician/ 3:10 Mary Peregov Martin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline 24300 Shore Highway Denton 8. Date of Birth January 2, 1928 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 ☐XF Months Hours Maryland Director 213-22-6237 82 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10h. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🗚 No Maryland | Caroline Denton 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 24300 Shore Highway 21629 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: "natural". Completed 3 Divorced White Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant. If item 27 is marked other than "natur ury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 HS Grad Homemaker/Teacher Family/Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Lillian Viola Twigg William James Peregov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24300 Shore Hwy., Denton, Maryland Samuel J. Martin/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oxford Cemetery Dec. 21, 2010 Oxford, Maryland ature of Funeral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. cook 21629 12 South Second Street, Denton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each list. Approximate erval Between Immediate Cause (Final Physician Medical resulting in death) Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed -tran and Due to (or as a consequence of) the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month Year Month Day Pregnant at time of death Unknown be detached g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 🗌 Yes 2 🗆 No Yes 2 funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 5 Residence After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after dealth. 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check within 2

State Registrar 30. Name and address of person who comple

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician**  $\underline{\boldsymbol{A}}^{\mathsf{M}}$ 15, 2:55 December 2010 <u>Elizabeth Chaney Merrick</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Denton Envoy of Denton If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 K F Director 96 July 20, 1914 Maryland 214-46-4250 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show notified at 1 X Yes 2 No Director Maryland Talbot Easton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a any hijury or other traumatic event, the M diral Examiner must bonce. U.S.A. 501 Dutchmen's Lane Room 107 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify Specify: Completed by White 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11 HS Grad. College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olivia Talbott Irving D. Chaney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Dembeigh Hill Circle, Baltimore, Maryland 21210 Charles P. Merrick, III 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Dec. 15, 2010 Dover, Delaware Capitol Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Moore Funeral Home, P.A. 22. Name and Address of Facility 12 South Second Street, Denton, Maryland 21629 23a. Part1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, [bisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death?
1 ☐ Yes 2 No 1☐ Yes 2 1 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Mann of Death 28c. Injury at Work? After (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death, I Director: / d in by the f 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0005325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Butter 13c Lednun am notesis and

Registrar

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31. Date filed (Month, Day, Year)

DEC 1 6 2010

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 2 per doc g912 2-23-11 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 06 Physician/ December 4 0702 AM SANDRA COOKLEY MORANT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville montgomery Grove Adventist Hospitan If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Months Hours Min. 02/10/1948 Country) Director 62 579-64-0618 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 ☐ No MD Columbia Howard 10e. Street and Number 10f Zin Code o 10g. Citizen of What Country? items 23a or ner must be r Funeral USA 5573 Cedar Lane 21044 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Was Deceue... Armed Forces? <sup>4</sup> □ Yes 2X No 14. Race - American Indian the Medical Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: 3X Widowed 4 ☐ Divorced "natural" Completed Black Sandra 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. Prince George's life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Center Lab Technician permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Annie Mae Coakley James Wilson 19a. Informant's Name/Relationship (Type, Print) Moran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19900 Sweet Gum Circle, #33, Germantown, MD 20874 Patrick Morant/son Baltimore, 20a. Method of Disposition 200. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
te of Neaven 1 X Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other (Specify) 12/18/10 Silver Spring, MD 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease or complica shock, or heart failure. Ust only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ 00 R 4 disease or condition Medical resulting in death) Due to (or a a onseq nce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): ertension Severe To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Failure esti Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Sarcoidosis the Funeral Director: After this certificate obleted filled in by the funeral director, pag 2 🗌 No 1 Tes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🛪 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident ☐ Accider☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Q N Fi M 29b. Signature and title of certifier 29c. License number 2 December 6,2010 D41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinu Ganti Doctor's Germantown MD MD 19529 Dr 20874 31. Date filed (Month, Day, Year) 37. Registrar's Signature State 14 DEC Registrar

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Physicia Medi		Decedent's Name (First, Middle, Rose Lena Marc	•						2. Date of De Decemb			) <b>TO</b>	3. Time of Death 1025 PM M
Examir	ner	4a. Facility Name (if not institution, Gilcrest Hospic	е			4b. City, Town, o		of Death			.County o		
Funeral Director		5. Social Security Number 577–34–4408  Usual Residence of Decedent	6. Sex 1  M 2  F	84		If Under 1 Year Months Days	If Under Hours		8. Date of Bir 03//01/91			9. Birthp Wash	place (State or Foreign Tington, D
∫ r 28a-f show notified at	Funeral Director	10a. State 10b. County DC None		,	Town or Loca	n							0d. Inside City Limits 1    Yes 2 □ N
nust be	neral I	10e. Street and Number 7401 Blair Road	NW			10f. Zip Code 20012				-	tizen of W		•
if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "hatural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	<u>\$</u>	11. Marital Status 1 □ Never Married 2 □ Marri 3 □ Widowed 4 ፟፟፟፟፟ Divorced	12. Was Deceden Armed Forces 1  Yes 2 If Yes, Give Year or Dates.	?	l If	as Decedent of H Yes, specify Cub ☐ Yes 2 No	an, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		14. Race Black Specify:	, White,	etc.
giene. ner than "nat t, the Medica	Sompleted	15. Decedent (Specify only highes Elementary/Seconday (0-12) 12		r 5+)	(Give ki life. DO	ent's Usual Occup ind of work done I NOT use retired, rk – typ	during mos	t of worki	ing		ind of Bus		dustry  f Agricul
Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle, La Emanuel Mille							e (First, Middle, Rudolph		Surname)	)	
it of Health and N If item 27 is ma or other trauma		19a. Informant's Name/Relationshi  Matthew Marcel  20a. Method of Disposition		Look Di-	519	Address (Street		reet	#203 E	3alti	imore	, MD	21201
		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	Adas	netery, crema S Israe Cer	ition (Name of atory or other pla el Congr netery		on 12		Wá	ocation - 0 ashin	igton	, DC
mportant: If any injury or		21. Signature of Funeral Service Lie		101163	<u> </u>	TU9I Ro					lle M	lb 20	852
ysician/ Medical kaminer		23a. Part 1. The disease, or of shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	y one cause on each II	ne.	TIC	the mode of dyir					R		Approximate Interval Between Onset and Death
been signed by the attending physician and should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last	с	s a conseque									
within 44 hours after deam.  To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buria		IF FEMALE; 23b. Was decedent premant in the past 12 months? 1 ☐ Yes 2 1☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknowr	2 Fetal of dea	death 3 🗌	Ectopic pregnand Other (specify) _	Э				23d. Date Mon		ery Day Year
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s certifik director,	To Be	25. Was case referred to predical examiner?  1  Yes 2 No	Hospital:	tient 2 🗆 Ef	9/Outpatient	Oth	er:			donne 6	Othor	/Cnooifu	ÎMSDICA
death. c <b>tor:</b> After thi y the funeral (	Certificate: 7	27. Manny of Death  1 Natural 5 Pending 2 Accident Investige 3 Suicide 6 Could no	28a. Date of in (Month, D)	ury 2i ay, Year)	3b. Time of injury	28c. Injur work	y at	Nursing Home 5 Residence 6 Other (Specify) HOSPICE  28d. Describe how injury occurred  No  28f. Location (Street and Number or Rural Route Number,					
	Medical Ce	4 ☐ Homicide determing  29a. Certifier 1 ☐ ertifying F	building, e	tc. (Specify)  of my knowled	lge, death oc	cured at the time	, date and p	place, and	City or Tow	vn, State) use(s) an	d manner	as state	d.
nours affer Ineral Dire d filled in b	崇	(Check 2 Medical Ex	aminar On the bacic of	evernination a	nd/or investig	ation, in my opinio	on, death oc	curred at	the time, date a	ind place.	and due	to the cau	se(s) and manner stat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 5:00p2. Date of Death Physician/ Month Nancy Lee Mullinix 20<sup>Y</sup>20 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster 8. Date of Birth
(Month, Day, Year)
1934 If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 - M 2 -XF Hours Min. Country) 219-32-7603 **Director** 76 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Glenelg Howard 1 Yes 2 XNo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral USA 21737 13901 Burntwoods Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes 2 X No 1 ☐ Yes 2 X No Specify: white permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa any injury or other traumatic event, the Medical Exa 3 🗆 Widowed 4 🗆 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) school bus contractor transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine McCracken George Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13901 Burntwoods Rd., Glenelg, MD 21737 Charles Robert Mullinix (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) View Cemetery 12-11-10 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Pargeofaight ferbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of, that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown ate has been signed by the atte page 2 should be detached for Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 INCBROVAS CUCAR 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 **No** 2 1 No 1 Tes Yes To the Hospital or Attending Physician: \ within 24 hours after death. To the Funeral Director: After this certifies 25. Was case referred to medical completed filled in by the funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Lether (Specify) 1 ☐ Yes 2 ☐ No 유 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) WJL 2010 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

DEC 1

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Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🕕 📗 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death university of Maryland ltimore Medical Ci . Social Security Number If Under 24 Hrs. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthday) Days 1 🟋 M 2 🗆 F 9-1/24/1-1/29 2020 PHTEATY PA 579-18-5997 88 **Director** Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE BOWIE 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 CLAIRTON DRIVE 20721 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ AYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 🗒 Yes 2 🔀 No Specify: Specify: BLACK 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 YRS • (1-4 or 5+) Elementary/Seconday (0-12) POSTAL CLERK U.S. POSTAL SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL B. McCOTTRY, SR. FREEMAN ANNA WIFE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORRAINE STOCKTON McCOTTRY-3801 CLAIRTON DR. BOWIE, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XX yurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN MEMOCEMETERY 12-20-2010 SUITLAND, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. \_E. 524 - 8TH ST. WASH. DC 20002-5236 N. 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last attending physician and I for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the g 
Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hypestension, CAD 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 XYes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 🗌 No Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimere, MD21201 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 9, 2010 9:30 Ам Ralph Eugene Mobley Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hyattsville Prince George's St. Thomas More Medical Complex 8. Date of Birth
Feb. 21, 1934 . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday Days South Carolina Director Feb. 577-42-4343 76 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5357 Blaine Street NE 20019 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 African American 1 ☐ Yes 2 🖾 No Specify: "natural", 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygliene. Important If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 9th Laborer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Mobley Beatrice Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Arline E. Mobley - Daughter 5357 Blaine Street NE Washington, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dec. 17 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Washington National Suitland, Maryland 21. Signature of Funeral Service Licens. 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part 1 Egter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Unevo se evolic Onset and Death Ph sician/ archievascular Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

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eral Director. After this certificate I filled in by the funeral director, page 1 Yes 2 No Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 🔲 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

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completed filled 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 006368 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835 University Blvd. E # 208 Ajit Kurup M.D. Hyattsville, Maryland 20783 31. Date filed (Month, Day, Year) State

Registrar

6 2010

DEC 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		rtment of H		nd Mental Hy	giene 2 (	010	41465
	Physic /Medi		1. Decedent's Name (First, Middle, Last)		МА	IORAN		2. Date of De Month DELEMBE	Day 1-8	Year 2010	3. Time of Death
. /	Exami	ner	4a. Facility Name (If not institution, give  The Johns Hopkins Ho  5. Social Security Number  6. Se	spital	st birthday)	4b. City, Town, or <b>Baltimore</b> If Under 1 Year	City If Under 2		4c. County	,	ace (State or Foreign
	Funeral Director		221-26-7824 1 5 Usual Residence of Decedent 10a. State 10b. County	XM 2□F 69	Yrs.	Months Days	Hours	July 24	th ay, Year) <b>4,</b> 1941		ace (State or Foreign y)  Laware  Od. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at once.	Funeral Director	Maryland Cecil 10e. Street and Number 56 Silchester Co 11. Marital Status	E	1kton	10f. Zip-Code 21921	spanic Orig n, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)			1 □ Yes 2 X No  ry?  ates  in Indian,
21215-0036	d within 72 hours afte giene. er than "natural", or the Medical Examin	Completed by F	1 Never Married 2 Married 3 Nidowed 4 Divorced  15. Decedent's Edi (Specify onfy highest grade)  Elementary/Secondary (0-12) 12	If Yes, Give Year or Dates:	16a. Deced (Give k life. D	☐ Yes 2 🏋 No  ent's Usual Occupa ind of work done of O NOT use retired)  pervisor	during most			Whi Business/Ind	ustry
Maryland	ould be file Mental Hy, larked othe atic event,	To Be (	17. Father's Name (First, Middle, Last)  Frank Anthony Ma				Ang	geline P.	Fortugue	0	On the l
nore, Mar	ages fand 2 sh nt of Health and : If item 27 is m or other traum		19a. Informant's Name/Relationship (Ty Shirley E. Maior 20a. Method of Disposition	ano/Wife  20b. Pla  Removal from State	56 Si ace of Dispos metery, crem	1chester	Cour	t, Elkton, December	MD 219	921 - City or Tow	vn, State
Baltimore,	permit. Pa Departmer Important any Injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Licks	22.	103 W.	ss of Facility Stock	Hicks Hometon Street	t, Elkto	uneral	ls, P.A.
)	Physician /Medical		23a. Part T. Enter the disease, or complete shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. RENAL FAI  Due to (or as a conseque	LURE		g, such as o	cardiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	ate be executed by hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, cooling to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. RENAL CE Due to (or as a consequence)  Due to (or as a consequence)	ends bit) 1	ANCER					
O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan  1  Live birth 2 Fetal    4  Pregnant at time of dea	death 3 🗌	Ectopic pregnancy Other (specify)	1			ate of deliver	ry Day Year
rds, P.O.	quires that t n signed by uld be deta	b	Part II. Other significant conditions co	ntributing to death but not resu	ilting in the u	nderlying cause giv	ven in Part I	. 23e. Did			e cause of death?
		Completed						24a. Was auto perfe 1  Yes		Were autop prior to cor death? 1 \( \sum \text{Yes}	osy findings available impletion of cause of 2 No
of Vital	siclan: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No	Hospital: 1	ER/Outpatient	3 □ DOA Othe	SF:	of Death <i>(Check only o</i>		ther (Specify)	)
Division of	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral d	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 Y	/ at	28d. Describe	how injury occu		
Divi	ital or Atteurs after de ral Directo	Certification:	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of injury - At hom building, etc. (Specify) siclan: To the best of my know			no deto one	City or To	. ,		
	n 24 ho	edical		Iner: On the basis of examination and manner stated.							
	To withi	Me	29b. Signature and title of certifier	M.D.		29c. License	9364	i l	29d. Date signed DECEMB		
_				DOUYERD		Print)		,			e, MD, 21287
	Sta Regist		31. Date filed (Month, Day, Year)  JAN 0 3 20	32. Registrar's Signatu	A. Ale	and I					

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 🗸 🖖 📗 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Morbec 19, 2010 Year Carol Ann Mencer 5:20 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Devlin Manor Nursing Home Allegany Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) MD 8. Date of Birth **Funeral** Months Days Hours Min Mul 26, °°°1954 **Director** 213-72-4396 Yrs. 56 Usual Residence of Decedent or 28a-f show notified at 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f shortranmatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 115901 Brice Hollow Rd. SE 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Virginia (Kenney) Nazelrod Omar Nazelrod of Health and Mer of Health and Mer fitem 27 is mark rother traumatic 19a. Informant's Name/Relationship (Type, Print) Roy Mencer Sr. 19b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip 115901 Brice Hollow Rd. SE Cumberland husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 1 🗆 Burial 2 🗆 🛛 emation 3 🗆 Removal from State Scarpélli Funeral Home, P.A. 12/22/2010 MD Cresaptown 4 Donation 5 Other (Specify) 21. Signature of Funeral ervice Licensee 22. Name an Scarpelli Full eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Pay 1. Entertine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ wh 3 day disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Fetal 35...
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s after death.

Director: After this certificate filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Poursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Tes 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DU017565 Dec. 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ND 21501 921 6262 le N2+ 1 Huy 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 U 1 U State
Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 15,2010 Physician/ December Di 1706 M Merrifield D. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince 3204 32nd Avenue Temple Hills Georges 8. Date of Birth (Month, Day, Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 🔀 F Months Hours Min. **Director** 56 578-76 -5033Wash Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location the Maryland other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits MD 1 XYes 2 No PG Temple Hills 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 3204 32nd Avenue 20748 United States Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Daniel Merrifield Jackson Sarah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juliette Drive Dawn Taliford/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit, Page 1
Department of
Important: If it
any injury or o 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md. National Cemetery 12/29/10 Laurel, Md. 21. Si matur of Funeral Service License 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death CARDVASCU Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months? Pregnant at time of death 1 Yes 2 9 Onknown 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate ha 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner2 Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending work?
1 Yes 2 No M 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier eted cause of death (Item 23a) (Type, Print State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 7 2:40 Рм Mariana E. Nuttle Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Talbot Easton William Hill Gardens If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Maryland 1 □ M 2 🗓 F Months Hours (Month, Day, Year) January 26, Director 85 218-16-6640 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 🕅 Yes 2 ☐ No 28a-f Maryland | Caroline Denton 10e. Street and Number or items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 106 Ellerslie Court 21629 12. Was Decedent Ever in U.S. Armed Forces?v 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: White 3 Nidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be flied within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 11 HS Grad, College (1-4 or 5+) Buyer retail clothing Clothing Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Rebecca Pastorfield John Lester Everngam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10426 Morning Dew Lane, Richmond, Virginia 23116 Charles T. Nuttle/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Capitol Crematory 12/8/2010 Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Moore Funeral Ilome, P.A. 21. Signature of Funeral Service License au a 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Failure Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 D 9 Unknown 9 Unknown the been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2, No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) Asst. Living 2 No |은 1 Inpatient 2 ER/Outpatient 3 DOA in 24 hours after death.

ne Funeral Director; After this pleted filled in by the funeral di 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 X Natural Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

State Registrar

Medical

29a. Certifier

(Check

31. Date filed (Month, Day, Year)

CRN 501 Dutchman's egistrar's Signature A STATE OF THE PARTY OF THE PAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas

DEC 0 9 2010

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RO77623

29d. Date signed (Month, Day, Year)

12-7-2010

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 24, 2010 11:15<sup>M</sup> Thomas Robert Nightengale Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 31 Jackson Street Lonaconing Allegany 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) April 18, 1945 Director Yrs 219-46-1839 65 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 X Yes 2 ☐ No Allegany Maryland Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31 Jackson Street 21539 **USA** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Daniel Thomas Nightengale Agnes Reed Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Nightengale - Wife 17304 Hummingbird Lane, Lonaconing, Maryland, 21539 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date December 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cumberland Crematory 27, 2010 Cumberland, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MEMMERATIC Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to jor as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Line of death
Pregnant at time of death
Unknown Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No the 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has bage 2 s death? 1 ☐ Yes 2 ♣ No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2 🔀 No Other: Certificate: To 1 Inpatient 2 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) n 24 hours after death.

e Funeral Director: After tholeted filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 02690 DECEMBER 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland, Mary land 924 Bishophbish Kood 03 3. Registrar's Signatur State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ POSTON Ellouise December 9:301 M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F May 21, 1938 Country) Director 72 GA 216-36-7124 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified. 1 Yes 2 X No Upper Marlboro Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3713 Halloway Pl. 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 A No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Various Companies Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ezekiel Hurst Rose Hurst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3713 Halloway Pl. Upper Marlboro, Md. 20772 James Poston, Jr. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harmony Memorial 12-13-2010 Landover, MD. Signature of Funeral Service Licensee Marshall-March Funeral Home of Maryland tas 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CardioThrombotic Physician/ disease or condition resulting in death) ) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 XNo Month Pregnant at time of death g 🔲 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Decrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

\*\*No Ray Up WMLM . D 29c. License number 29d. Date signed (Month, Day, Year) D0057465 12/8/16 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

N. S. Rujapakse MD

31. Date filed (Month, Day, Year)

N-J-203 -

Baltimor ND. 21209

2835 Smith

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER Day 6 2010 8:00 P M PENNY Ε. DEXTER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours MARCH 22 1 X M 2 🗆 I MARYLAND Director 50 1960 <u>219-72-6412</u> Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗆 No MARYLAND PRINCE GEORGE'S DISTRICT HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20747 2705 BOONES LANE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc \$ 1 Never Married 2 Married Yes 2 No Yes, Give 72 hours after Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE 12TH CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 THELMA WALLACE HENRY NAPOLEON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 5331 BROWNS WAY CHURCHTON, MARYLAND 20733 DIANE M. PENNY/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State LOTHIAN, MARYLAND 12/15/2010 4 Donation 5 Other (Specify) MOSES CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition COLON ancer Priysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de و ک or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 X No 1 ☐ Yes 2 ☑ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medica To Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 \( \subseteq \text{Nursing Home} \) 5 \( \subseteq \text{Residence} \) 6 \( \subseteq \text{Other} \) Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 18792004 P mukemil Andellaimo 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdellaimo 12200 ANNAPOLIS ROAD SUITE 229 GLEN DALE, MD 20769 Mukemil 31. Date filed (Month, Day, Year) State DEC 1 5 2010 Registrar

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	Dhusisi		1. Decedent's Name (First, Middle, La	st)					2. Date of De Month			3. Time of Death	_
	Physicia /Medic		Dani Sue Paulin							BER	13,2016		1
	Examin	er	4a. Facility Name (If not institution, giv		,			LATA		4c	. County of Deat		
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	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town	or Location					10d. Inside City Limit	s
	a-f sh	ctor	Maryland Charle	es	In	diar	n Head					1x Yes 2 □ N	0
	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. do ther than "natural", or items 23a or 28a-f show event, It e Medical Eranical must be redified at	Directo	10e. Street end Number 4 Prospect Ave.				10f. Zip Code 2064	n			tizen of What Co	ountry?	
	ns 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	S.			ecify Yes or No		14. Race - Ame	erican Indian,	
စ္	after o		1 ☐ Never Married 2 Married	Armed Forces? 1 □Yes 2 □ If Yes, Give			13. Was Decedent of H	an, Mexican, Puerto  Specify:	Rican, etc.)		Black, White	e, etc.	
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က်	in 72   n "nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		168. [	Dece <b>de</b> nt's Usual Occup 'Give kind of work done of life. DO NOT use retired	ation during most of work d)	ing	16D. K	(ind of Business/	Industry	
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Ze,	of H		20a. Method of Disposition		20b. Pl		Disposition (Name of crematory or other place		Date 2010	20c. L	ocation - City or	Town, State	
altimore,	. Pages tment of tant: If it jury or o		1 ☐ Burial 2 🂢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)			olitan Fune	ral Servi	ce		kandria,	Virginia	
Ba	permit. Page Department Important: If any Injury o		21. Signature of Funeral Service Licer	///	*0066	0	22. Name and Addre	ss of Facility Funeral H	ome, P.	Α.	hw ha	20640	
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	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of	):					· MALLOWER .	
		er	Sequentially list conditions, if any leading to immediate	Due to (or as	a consequ	ence of	CMONPR	A 1-AMB	45 /C - C 15	W) ]	-010 1	A lacatation	7.
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Rox	death certificate e attending phys d for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			оП				23d. Date of de	livery	
о В	the atte	Physician/Medica	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 □ Live birth 4 □ Pregnant a 9 □ Unknown			3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у			Month	Day Year	
J	that the		Part II. Other significant conditions of	ontributing to death b	ut not resu	Iting in 1	the underlying cause giv	en in Part I.	23e. Did t	obacco	use contribute to	the cause of death?	
Vital Records,	w requires that the de sbeen signed by the should be detached	ed by							1 🗆 '	Yes 2	<b>√</b> No 3□P	robably 4 🗆 Unknow	/n
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DIVISION	after cafter ertification:	4 Homicide determined	building, etc	iry - At noi c. <i>(Specify</i>	me, tarr	n, street, factory, office		City or To	Street a wn, Stat	nd Number or H e)	ural Route Number,		
:	to the nopplate of Attending Priysician: The law within 24 bours after death.  Within 24 bours after death.  Within Enueral Director. After this certificate has completely filled in by the funeral director, page 2 s.	Medical C	29a. Certifier	nysician: To the best niner: On the basis o and manner sta	f examinat	wledge, ion and	death occurred at the til /or investigation, in my c	me, date and place ppinion, death occur	, and due to the red at the time,	cause( date an	s) and manner and place, and due	s stated. e to the cause(s)	
	To the comp	/ Me	29b. Signature and title of certifier	Mall		-1	29c. Licens	e number	-9.	29d. Da	ate signed (Mont	th, Day, Year)	
71	310		30. Name and address of pirson who	ppleted cause of d	eath (Item	23a) (T	ype, Print)	JA n	M N A	11.	75	5001	
1	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure	bares	V11010	1-1, 1	710	A. C.	7	
	Registra		DEC 15	2010 Jane	un	D.	garles						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 Veal Henry Clay Porter, Sr. 35 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** licomico Poninsula Regional Medical Center Ilisbur Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year Months Days Hours Director 91 919 212-16-7659 Maryland VOV Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Caroline Federalsburg 1 Yes 2 No MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ral", or items 23a or Examiner must be r 21632 United States 26171 Auction Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. II WW 3 Nidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Mechanic Automotive 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eliza Trice George Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon I. Dulin/Daughter 6502 Federalsburg Hwy., Federalsburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Concord Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/18/10 Federalsburg, MD injury 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A CFSP 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Day ed by the a detached f 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl performed? 1 ☐ Yes 2 ☐ No Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 T No ည 1 🕒 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After this funeral c 27. Manne Teath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Director: / Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie R076822 30. Name and address of person who completed cause of death (Item 23a) Type, Print) E. Carroll St. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:10p M Elizabeth Helena Pellar December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery 14316 Blackmon Drive 9. Birthplace (State or Foreign Country) Washington, DC 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 🗆 M 2 🕱 F Months 577-42-3653 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 2 should be filed within 72 hours after death with the Maryland thit and Mertal Hygiene.
27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Montgomery Rockville 1 Tes 2 X No 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14316 Blackmon Drive 20853 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dietary Manager Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Tenly Carl Marion Toepfer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14316 Blackmon Drive, Rockville, Maryland 20853 Cynthia L. Merriam - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Gate of Heaven Cem. 12/15/2010 Silver Spring, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. AnneManewurkon 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Sepsis Medical resulting in death) Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should he detached for use as the hours is the funeral director. ed by the attending physician and detached for use as the burial-transit Atherosclerosis Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 X No 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital မ 1 Tes 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury\_at X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation ☐ Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D23459 December 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18109 Prince Philip Drive, #275, Olney, Maryland 20832

State

Registrar

Edward Taubman.

14 2010

31. Date filed (Month, Dav. Year)

M.D. .

			Please Type or Print in Black Inde									
		-	State of Maryland / Departm	nent of Health and M cate of Death		L 0 1 0	414/5					
			Registrar Certific  1. Decedent's Name (First, Middle, Last)	Jale of Death	2. Date of Deat	leg. No.	3. Time of Death					
	Physicia Medic		Syprian Marissa Palmer		Month	Day Year	1535 ? M					
	Examin		4c. County of Dear									
أبسه			Shady Grove Adventist Hospita1  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Rockville  Under 1 Year   If Under 24 Hrs.	8 Date of Birth	Montgo	thplace (State or Foreign					
	Funeral Director		None 1 $\square$ M 2 $\square$ F 0 Yrs. Months Days Hours Min. (Month, Day, Yeaf) October 9, Ma									
	d tow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits					
	arylan la-f sh ified a	ecto	Maryland Prince Georges Hyattsvi				1 <b>X</b> Yes 2 □ No					
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 6210 Belcrest Road; Apt. 1321	f. Zip Code <b>20782</b>		10g. Citizen of What Co United S						
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Baltimore, Maryland 21215-0036	be filed vental Hygrked other	To Be	17. Father's Name (First, Middle, Last)  William Ruterford Palmer, III	18. Mother's Name Shervor	e (First, Middle, l Denis							
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<u>ა</u>	and 2: Health em 27 ther tr		Shervon Denise Wilson (Mother) 6210 Be	lcrest Road;Apt		20c. Location - City or						
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alti.	mit. P. sartme sortar sortar / injur			ne and Address of Facility R. N	I. Horto							
m	permi Depar Impol any ir			;600 Kennedy St			ton,D.C.20011					
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	Examiner		Sequentially list conditions.  NECADTIZING ENTEROCOLIT	is Totaus			12 Days					
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P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death certificate be within E4 hours after death. After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 N No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ect 4 Pregnant at time of death 5 Oth	23d. Date of de Month	23d. Date of delivery Month Day Year							
<u>0</u>	that the need by e detail	by Pl	Part II. Other significant conditions contributing to death but not resulting in the under			bacco use contribute t	_					
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Division of Vital Records,	The law re ate has be page 2 sh	Completed by	HECHBOOTEDENIA, ANEMIA, HIPOKALEHIA, CIRONIC hans	sy prior to med? death?	utopsy findings available completion of cause of es 2 No							
tal	ician; vertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check								
Ž	Physic r this erral dir	<u>ان</u>	1 Inpatient 2 ER/Outpatient 3  27. Manner of Death 28a. Date of injury 28b. Time of	☐ DOA 4 ☐ Nursing Ho		ence 6 Other (Spe ow injury occurred	cify)					
uc	nding ath. r: Afte e fune	icate	1 X Natural 5 □ Pending (Month, Day, Year) injury 2 □ Accident Investigation	work? 1 ☐ Yes 2 ☐ No								
ivisi	I or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, for building, etc. (Specify)	actory, office	28f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,					
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 or	Medical	29a. Certifier (Check only one)  1	on, in my opinion, death occurred a	t the time, date a	nd place, and due to the	cause(s) and manner stated.					
	To the within To the comp	2	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon						
			X.) ESTILLIMB	68218		12/9/2010	=					
	3/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kisha Destin, M.D.; 9901 Medical Center	r Drive; Rockvi	lle,Mar	yland 20850	)					
	Sta Registra		31. Date filed (Month, Day, Year)  DEC 1 7 2010  32. Registrar's Signature	,	<u></u>	i <sup>e</sup>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 45 AM cember 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital Baltimore City 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreigr Country) **Funeral** 1 □ M 2 🔀 F Days Yrs **Director** 578-02-0789 46 May 6,1964 Wash. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Examiner must be notified at 1 XYes 2 No Director 28a-f Montgomery MD Silver Spring 10e. Street and Number 10g, Citizen of What Country? 10f. Zip-Code 23a or 8710 Cameron St. #917 Funeral 20910 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 þ 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: 'natural", Black Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than Accountant DC Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilbert Fletcher 2 Catherine Snowden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8710 Cameron St. #9 Silver Spring, Md. #917 Ronald Payne Sr/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 12/28/10 Brentwood, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy atter Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 1 ☐ Yes 2 ☐ No certificate 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA မ 6 Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury s after death.

Director: Aft
d in by the fu 1 Tyes 2 No 2 Accident Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) December 21,2010 30. Name and address of p erson who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 00 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MASSER Registrar

Die.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 28f per me 8913 3-11-11 of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ December 10 9 EZOAM Claire Robison Naomi Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City. Town, or Location of Death Doctors Community Hospital Prince Georges Lanham Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 D M 2 X Pennsylvania Months Hours Min. **Director** 209-01-4953 95 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits 1 Yes 2 No Prince Georges Landover Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4224 70th Ave. 20784 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Specify: White 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Aaron Quay Williams Anne Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12704 Bermuda Lane Bowie, MD 20715 Lenna Unland (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛛 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Presbyterian Cem. 12/16/2010 Port Matilda, Pa Signature of Funeral Service Licenses 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year been signed by the should be detached 1 ☐ Yes ∠ ≥ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ျ Yes Inpatient 2 - ER/Outpatient 3 - DOA Date of injury (Month, Day, Year) 27. Manner of Death of 28c. Injury at work?

M 1 🗆 Yes 28b. Time of 28d. Describe how injury occurred Fellet Certificate: Natural Accident 5 Pending December 6, 2010 Investigation **Director:** the Funeral Directory filled in by the 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f ocation ( reet and N mber or Rural te Number, determined home πην πην Bowie, certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and mann r as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the Leaf of my knowledge death optimized at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 12/10/ mens 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hucked, hankam, MIS. 20706 Momas Hain 3118 Good 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 8:08 P M Linda Α. Redd 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2504 Eliot Place Prince George's Temple Hills Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Age (li 9. Birthplace (State or Foreign (Month, Day, Year) 10/18/192 1 □ M 2 😿 F Months Days Hours Min. Director 578-40-1873 Guyana Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Prince George's Temple Hills XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2504 Eliot Place 20748 USA Was Decedent Ever in U.S. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc 1 Never Married 2 Married 2 Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Downstate Medical Elementary/Seconday (0-12) College (1-4 or 5+) Medical Record Librarian years Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of
any injury or other traumatic eve မ William Alonzo King Adelaide Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Desiree Cumberbatch/Daughter 2814 Beverley Road Brooklyn, NY 11216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md Veterans Cemetery 12/20/2010 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home Vnah Freal 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cerebral Vascular Accident disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Uncontrolled Hypertension Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 ending physics as the t 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) the 9 Unknown 9 🗆 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, Completed 1 ☐ Yes 2XXXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 🔀 No 2 X No 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 😾 Natural 5 Pending Division 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Continuing Number Practioner: It this best of my knowledge doubt continue the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D41182 12/13/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Felton Anderson, MD 8507 Oxon Hill Road suite 102 Fort Washington, MD 20744 31. Date filed (Month, Day, Year 32. Registrar's Signature DEC 1 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:14AM Wilbert Randolph Medical December 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington Advenist Hospita] Takoma Park Mont gomery

9. Birthplace (State or Foreign Country) ocial Security Number 8. Date of Birth **Funeral** 1 🖵 M 2 🗆 F (Month, Day, Year) Months Davs Hours Min. Director 46 244-17-2297 NC Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director 10d. Inside City Limits 1 🙀 Yes 2 □ No MD PG Temple Hills 10e. Street and Number 10g. Citizen of What Country? Funeral 2010 Colebrooke Drive 20748 United States death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Lvo Armed Forces? 1 ☐ Yes 2 🙀 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Randolph Oscar Annie Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 2010 Colebrooke Drive Frank Randolph Sr/brother 20b. Place of Disposition (Name of cemetery, crematory or other place)

Temple Hills, Md. 207
Date 4 8 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Park | 12/17/10 | Landover, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rá.,Suitland,Md.20746 23a. Par 1. Enter the disease, or complications that causer the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYO CARDIAL disease or condition resulting in death) CUTE Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a d be detached f 1 ☐ Yes 2 L 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ RESPIRATORY FAILURE or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed ENCEPHALD PATTY ANOXIC 24b. Were autopsy findings available prior to completion of cause of death? has performed? Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 HNo ည 1 Inpatient 2 FER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iours after death. Ieral Director: Af filled in by the fu 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Hospital Medical To the Hosp within 24 hou To the Funer completed fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number JOD & 16 29d. Date signed (Month, Day, Year) D40324 DECOMBOR 8, 2010 ress of person who completed cause of death (Item 23a) (Type, Print) TERMY JODRIE, MD, FACED 7600 CARROLL AVENUE, MARYLAM TAKOMA PARK. 32. Registrar's Signature State 5 2010

Registrar
DHMH 17 Rev 7/2009

3altimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Day 2010 Patricia Ann Ragland 12:01 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince George's Hospital Prince George's If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 22 1 □ M 2 🔀 F Hours Min <sup>∍ar)</sup>195<u>3</u> DC 57 579-72-2134 Director Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Prince George' Fairmont Heights Md 1 X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a or ner must be n ö Funeral 704 61st Ave 20743 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or iten edical Examiner r 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1X Never Married 2 ☐ Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Supervisor 12th 12 should be filed wii lith and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Victoria Aull Randolph Albert Ragland permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Damein Patrick Ragland 704 61st Ave Fairmont Heights Md 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 17th cemetery, crematory or other place)
Cedar Hill 1 A Burial 2 Cremation 3 Removal from State Dec Suitland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 . Signature of Funeral Service License 22. Name and Address of Facility McLaughlin's Funeral Home 2019 MLK Jr Ave SE, Washington DC 20020 Part N Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Se wentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retail do... 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Day Month Year 5 Other (specify) the g Unknown page 2 should be detached a 🗌 Unknown signed by conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 X No 2 🗌 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 Νn 1 Tes |은 patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this . Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 2 No death. Accident Investigation the Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mail Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mail (Check To the I within 2 29d. Date signed (Month Day, Year) 29b. Signature and title 5 ne and address of person who completed cause of death (Item 23a) (Type, Print) James Catevenis 3001 Hospital Dr Cheverly Md 20785

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

10-09798 Sharon Yvette Ross

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 11481

		1- For State		Certi	ficate of D	eath		Re	g. No.	
Physic	cian/	Registrar  1. Decedent's Name (F	First, Middle,Last)					Date of Death     Month	Day Year	3. Time of Death
al Exan		Sharon	Yvette Ross					December	19, 2010	1418 hrs
			ot institution, give street and numbe				ocation of Deal	h	4c. County of Deat	h
		Bloomingdale	Avenue at Federalsburg H	ighway		ederalsburg			Caroline	
Funera	al	5. Social Security Num	nber 6. Sex 7. A	ge (In yrs. last		f Under 1 Year	If Under 24H		h(MM/DD/YYYY) 9. Bi	an
Directo	r	214-66-9	9370 1 M 2X F	5		Months Days	Hours Mi	Dec. 2	9, 1955	ountry) MD
		Usual Residence of De	ecedent							
a a b		10a. State 10	b. County	10c. City, To	own or Location					10d. Inside City Limits
br work	<u> </u>	MD	Caroline		Fed	eralsb	ourg			1 XYes 2 No
Aaryland 28a-f show	1 5	10e. Street and Numb			10	of. Zip Code			g. Citizen of What Co	
be Mi	al Director	3430 Ho	lland Drive				21632		United St	tates
with t	Z Z	11. Marital Status	12. Was Decede					Specify Yes or No-	14. Race - Ame White, etc.	rican Indian, Black,
eath	Funeral	1 XXNever Married	2 Married Armed Force	s? 2 <b>X</b> No	If Yes,	specify Cuban,	Mexican, Puer	o Rican, etc.)		lack
fter d	y F	3 Widowed	4 Divorced If Yes, Give Year or Dates:		_	s 2 X No			Specify.	
ours a	d by	15. Decedent's Educ	cation (Specify only highest grade co	ompleted) 1	6a. Decedent's		on (Give kind o DO NOT use re		16b. Kind of Business	/Industry
72 h	et le	Elementary/Second	· · · ·	r 5+)	Medica	_		,	Medical	L
O30	ompleted		2					ne (First, Middle, N	1-14 (	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	မြ	17. Father's Name (Fi				1		ta Pric		
121 be fi	Be i		J. Ross		40h Barilina A	ddroon (Shoot			nber, City or Town, Star	te Zin Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other "matural", or items 23a or 28a-f the	7		e/Relationship (Type, Print ) Ross/Daughter		11323	N. 50th	st. #1	6, Tampa	, FL 33617	, z.p 3327
MD nd 2 shc alth and m 27 is		20a. Method of Dispos		20b. Pla	ce of Dispositio			Date	20c. Location - City of	
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.			Cremation 3 Removal from	State cre	matory or other	place)	4.0	/28/10	Denton, M	amul and
Pag Pag	5 o	4 Donation 5		Ros	s Chape		<u> </u>			
Salt simit. eparti	lang.	21. Signature of Fune	1 1.0			e and Address	г	ramptom	Funeral Ho	me, P.A.
	_	Michael	disease, or complications that cause	ad the death C	216	N. Mai	n St.,	Federals	burg, MD 2	Approximate Interval
hysicia /Medic		23a. Part I. Enter the failure. List only	one cause on each line.	o the death. L	o not enter the	node or dying,	Such as calcia	or respiratory an	000, 011001, 01110011	Between Onset and Death
Examine		Immediate Cause (Fir								
		or condition resulting	240 (0. 40 40 40	nsequence or):						
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760, icate be	g He	IF FEMALE: 23b. Was decedent pr	regnant in the 23c. If yes, out			death 3 [	Ectopic preg	nancv	23d. Date of delive Month	Day Year
cords, P.O. Box 687 aw requires that the death certific nas been signed by the attending I	ched for use as the Physician/	past 12 months?	- Live birti	at time of deat	=	· (Specify)		,		
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of Vi ing Physi	ᆵᅵᄂ	1 Yes 2	No 28a. Date of		28b. Time of Inju		ry at Work?	28d Describe	how injury occurred	
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SiOr Attend r death ector:	E la	2 🗸 Accident	Investigation 28e. Place o	f Injury - At hor	ne, farm, street,	factory, office b	ouilding, etc.		Street and Number or	Rural Route Number, City
Division of Vital Records, P.O. spital or Attending Physician: The law requires that thours after death.	filled in by the funeral Certification: T	3 Suicide Homicide	o Coula not be	/lajor Road				or Town,	State) e Avenue at Federal	sburg High, Federalsbur
lospit † hour			Certifying Physician: To the best of	f my knowledge	e. death occurre	d at the time, da	ate and place, a	nd due to the cau	se(s) and manner as s	tated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial.	completely	(Check only one) 2 V	Medical Examiner: On the basis of e	xamination an	d/or investigation	n, in my opinior	n, death occurre	d at the time, date	and place, and due to	the cause(s)
\$ 1 × 1 × 1	io Z	29h Signature and the	and manner state	7/10	2 17	29c. Licens	se number		29d. Date signed (f	Month, Day, Year)
		2/-ts	0// // /lone	1/ 38	36	O.C.	M.E.		December 20,	2010
		30 Name and address	ss of person who completed cause	of death (Item :	23a)				<del></del>	
		Victor Weedr				nn Street, E	Baltimore, M	D 21201		
	State	31. Date filed (Month		strar's Signatur	е		<del>.</del>			
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Louis Ear1 Rosier 2010 December 1:50pMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Carroll Hospice Dove House Westminster . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Hours (Month, Day, Ye 87 **Director** 219-18-8515 923 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll Eldersburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 984 B Tonia Court 21784 12. Was Decedent Ever in U.S.

Armed Forces?

1 X Yes 2 No 1943If Yes, Give 1046 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐XNo Specify: Completed 3 X Widowed 4 Divorced 1946 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) International Harvestpartsman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nellie May Hanna Clarence Clayton Rosier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Rosier (daughter) 984 B Tonia Ct., Eldersburg, MD 21784 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 12-8-10 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Paign Jaight Stenbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between PATIC Onset and Death Immediate Cause (Final Acut Ph sician/ wee disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant in the past 12 month g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by PECURIANE SMCLO bowel obstruction 1 Yes 2 No 3 Probably 4 Unknown CHRONIC Kidney disease Shage I 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 ☐ No DONE HOUSE Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3166C 12/6/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sai stuned Avenue WESTMINSTER MARYLANI THOMAS K. GALVIN vi c - MO 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Monto Physician/ Rankin William Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany WMHS-RMC Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpieco . Country) MD **Funeral** 1 □ M 2 □ F Hours Min. Jun 8, 89 219-03-9172 Director Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must han account. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Cumberland MD Allegariy 1 ☐XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10501 Jeffries Road NE 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗆 No WW II Specify. white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Railroad laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Florence Lydia (Wagner) Rankin Samuel Alonza Rankin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code
11810 Messick Road SE Cumberland MI Tina Labutka MD 21502 daughte 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State Rocky Gap Veterans Cemetery 12/21/2010 Flintstone MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funer Service Licensee 22. Name and Address of Facility Property Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the tilse se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset Death Immediate Cause (Final disease or condition Ruysician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ng physician and as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Lecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Trefriging Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title DO033280 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 KENT AVENUE CUMBERLAND 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ 7:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany 504 Oldtown Road Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8 Date of Birth Birthpiac . Country) MD Funeral 1 □ M 2 □ x Apr 26 Director **214-05-8**391 99 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Cumberland MD Allegany 1 □xYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 504 Oldtown Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: 3 □ Widowed 4 □ Divorced Specify: white Year or Dates. permit, Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Ella (Welshans) Weber Albert L. Weber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 312 Prince George Street Cumberland ML 19a. Informant's Name/Relationship (Type, Print) Kathleen Stafford MD 21502 niece 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 12/18/2d10 Cumberland MD 4 Donation 5 Other (Specify) Sign fore of Funer Service Licensee 22. Name and Address of Facility Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 harf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 21 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsv perform 24 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2/No Other: ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1/2 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Decirion Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The three Praction of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 1208773 12 15 (tam 23a) (Type, Print) 30. Name and address of person who completed cause of deat LOS IL Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010 Рм 7:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Thomas More Nursing Home Hyattsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 1 F Months Days Hours Min. (Month, Day, Year) 1939 LaPlata Director 579-50-7689 71 December 13. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 K Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? or than "natural", or items 23a of the Medical Examiner must be Funeral 20018 USA 2420 Oueens Chapel Rd., NE, Apt 1 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 ₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'lury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Maintenance Supervisor 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Catherine Hawkins Armand Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2420 Queens Chapel Rd, NE, Apt. 1, Washington, DC 20018 Catherine Harris - Daughter 20b. Place of Disposition (Name of Date 20c Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or ot cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery 12/22/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home . Signature of Fundal Service License Kennedy Street, NW, Washington, DC 716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final h sician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year Pregnant at time of death 1 | Yes 9 | Unknown signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred  $\odot$ Natural Accident 5 Pending work 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital within 24 hours a To the Funeral C Hospital Medical 29a. Certifier Dectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiners On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurs e best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 12/06/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

4922 Lasalle Road, Hyattsville, Maryland 20782

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month F. Robert Simms Decembe 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 4419 23rd Pkwy #201 <u>Temple Hills</u> Prince Georges 8. Date of Birth (Month, Day, Year) May 2.19 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 🗆 F Months Hours **Director** 1949 Wash DC 215-52-9082 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 😾 Yes 2 🗌 No Hills Temple MD PG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 4419 23rd Pkwy 20748 #201 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Completed Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Contractor Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Simms Sydney Proctor Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4419 23rd Pkwy #201 Elaine E. Simms/wife Temple Hills, Md. 20a, Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 12/10/10 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory Riverdale, Md 21. Signature of Funeral Service Licenspe 22. Name and Address of Facility Hodges & Edwards F.H. 0 Silver Hill Rd., Suitland, Md. 20746 3910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Non Small Cell Priysician/ Differentiated disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Embolism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Pulmonary Completed Stroke 24b. Were autopsy findings available prior to completion of cause of 24a. Was an sate has t page 2 s autopsy performed? Yes 2 No death? Yes 24 hours after deau...

E Funeral Director: After this certifice hated filled in by the funeral director, plated filled f 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ☐ No မ 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar MI

3800 Reservoir Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Inecler

32. Registrar's Signature

MARGOT

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jose Salvador Garcia Sanchez December \$ 30 PM 10,2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Aug. 6, 1965 none 45 El Salvador Director Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** must be notified 1 Yes 2 No Maryland Prince Georges Lanham 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 9509 Underwood St. 20706 El Salvador 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "If item 27 is marked other than "natural", or iter or other traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 K Married Page 1 and 2 should be filed within 72 hours after 1 X Yes 2 No Specify: Salvadorian 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Construction DJB Contracting Inc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Guillermo Garcia Umana Teresa Sanchez Hernandez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 9509 Underwood St. Lanham, MD 20706 Jose Luis Sanchez (Brother) permit. Page 1 and Department of Heali Important: If item 2 any injury or other Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Cementerio General 12/22/2010 La Union, El Salvador 22. Name and Address of Facility Rendon/Hale Funeral Home Signatur of Funeral Service Licensee 9013 Annapolis Rd Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ ephc Shoc Medical Examiner Soone field list end litters Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a conseq ence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: . If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 🗓 Yes 2 🔲 No 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and ti of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - l'izab Q.Hr

State

Registrar

31. Date filed (Month, Day, Year,

DEC 1

5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 2010 5:50P Helen Arlene Swann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charles 15440 Mathews Manor Road Newburg If Under 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number Funeral July 12, 1 🗆 M 2 🗓 F Months Days Hours Maryland 1950 60 Director 219-56-1141 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🄀 No MD Charles Newburg 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20664 IISA 15440 Mathews Manor Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Yes, Give "natural", 3 Widowed 4 Divorced White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Toll Manager Maryland Transportation Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen McDonald George Goldsmith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15440 Mathews Manor Rd. Newburg, MD 20664 William Swann/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot tholy Ghost Cemetery 12/15/2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Issue, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00945Signature of Funeral Service Licensee 22. AREHART ECHOL'S FUNERAL HOME, P.A. a Mary's Ave. La Plata.MD St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARC 0 disease or condition resulting in death) Medical Due to (or as a consequence of) WK. Examiner ETASI Sequentially list conditions. n any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 2 🗌 No Division of Vital Records, 1 🗌 Yes been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner?
1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 3 □ DOA |은 1 Inpatient 2 I ER/Outpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 only one title of certifie 29b. Signatu 0 1 and address of person ho completes cause of death (Item 23a) (Type, Print) XB6 31. Date filed (Monti Registrar's Signatur State 5 woul Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ December Carolyn Geraldine Shull 2010 2:28 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Nursing Home Denton Caroline 7. Age (In yrs. last birthdav) 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Days November 9 1 M 2 TXF Hours New Jersey Yrs 1940 169-36-7347 70 Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Denton Maryland Caroline 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21629 RD 3, Matthewstown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 XNever Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced 4 Divorced White Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 H.S. Graud College (1-4 or 5+) Graud Justice of the Peace Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Ruth Gaines William Benjamin Shull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23126 Deer Run Court, Denton, Maryland William E. Shull/brother 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Capitol Crematory Dover, Delaware 4 Donation 5 Other (Specify) Moore Funeral Home, P.A. 22. Name and Address of Facility of Funeral Service Na 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deati shock, or heart failure. List o Immediate Cause (Final Physician ONS disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) the past 12 mor Month Day Pregnant at time of death Yes 2 No the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? is certificate has been signed I director, page 2 should be det Completed by 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 \sum Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one 29b. Signature and title of certifier

Registrar

30. Name and address of person

1629

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	laryland				and N	/lental Hy	giene	Ont	2 110
			Registrar			Cer	tificate of	Death			Reg. No.	401	0 41491
	Physicia	an/	1. Decedent's Name (First, Middle,	•						2. Date of De	eath Day	Year	3. Time of Death
	Medi	cal	Harold Eugene  4a. Facility Name (if not institution.)			<del></del>				Decent	Sec 18	2 2010	0323 M
	Examir	ıer	Memorial He				4b. City, Town,	4	of Death			County of Deat	h 
	Funeral				ge (In yrs. las	t birthdav)	If Under 1 Year	iton	24 Hrs.	8. Date of Bir		10/60	hplace (State or Foreign
	Director		215-32-6620	1 🕅 M 2 □ F	75		Months Day		Min.	February	y, 124r) 1	1935 ° Col	Maryland
	» A		Usual Residence of Decedent										
	yland -fshq edat	ctor	10a. State 10b. County		10c. City,	Town or Loc							10d. Inside City Limits
	e Mar r 28a notifi	Jire	Maryland Caro	line		Der	ton						1 🔀 Yes 2 □ No
	ith th	rall	325 Carter Aven	110			10f. Zip Code	21629			-	en of What Co	untry?
	hours after death with the Maryland natural", or items 23a or 28a-f sho lical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.		as Decedent of		ain? (Spe	cify Yes or No-		4. Race - Amer	rican Indian
9	or it	by F	1 ☐ Never Married 2 🗓 Marrie	Armed Forces? d 1 ☐ Yes 2 ☐	7	If	Yes, specify Cul	ban, Mexicar	n, Puerto	Rican, etc.)		Black, White	e, etc.
93	ırsaft ural", IExa	ed	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2 🖁 N	No Specify:			S	ipecify: Whi	ite
5-(	72 hou n "nati Aedica	Completed	15. Decedent (Specify only highes			16a. Decede	ent's Usual Occi	upation e <i>durina mos</i> :	t of worki	'na	16b. Kin	d of Business I	Industry
121	within 7 giene. er than , the Me	l m	Elementary/Seconday (0-12)	College (1-4 or	5+)	life. DC	NOT use retire	d)		-19	M .	. 1 0	٠.
42	filed wi al Hygie d other	l ou l	17. Father's Name (First, Middle, La	st)		Mali	tenance		or's Nome	e (First, Middle,			Government
<i>Smith</i> Maryland 21215-0036	be filk ental <b>ked</b> c	卢	Eli Smith							ckling	Maideri St	итате)	
ary ary	should and Me		19a. Informant's Name/Relationship	(Type, Print)	1	19b. Mailing	Address (Stree	•			er. City or To	own, State, Zic	Code)
	d 2 sl alth a 1 27 i		Pauline S. Smit	h/spouse	1:		rter Av					21629	,
Harold Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	П В От	20b. Pla	ce of Dispos	ition (Name of atory or other pl	lace)	[	Date	20c. Loc	ation - City or	Town, State
22 mi	permit. Page Department o Important: If any injury or once.		4 Donation 5 Other (Sp		' I		metery		Dec. 1	.5, 2010	Dent	on, Mar	vland
₹ Salt	permit. Depart Import any inj once.		21 Ignatur of Funeral Service L	900		- 1	Name and Add	ress of Facilit	y N	Moore Fu	unera	1 Home,	P.A.
	= α ο		ramopy	noon			2 South					n, Mary	land 21629
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that cause y one cause on each lin	d the death.	Do not enter	the mode of dy	ing, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Card	lion	yopo	They					-	Onset and Death
	Examiner		your and any	Due to (or as	a conseque	of of):	12	ds	0100	2			yeurs
		Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a euneequer	nce of):	2						7
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	C									
	ath certificate be executed attending physician and for use as the burial-transit	Ĕ	resulting in death) Last	Due to (or as	a consequer	nce of):							
09	te be hysici he bu	edical		d									
	rtifica ling p e as t		IF FEMALE:	00 1/	,								
Box 687	or us	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal d	leath 3	Ectopic pregnar				23	3d. Date of deli Month	very Day Year
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ∐ Pregnant a 9 ☐ Unknown	it time of dea	atn 5∟	Other (specify)					Month	Day Tour
P.O.	ician: The law requires that the descertificate has been signed by the rector, page 2 should be detached	by Physician/M	Part II, Other significant condition	contributing to death b	ut not result	ing in the un			l.	23e. Did to	obacco use	e contribute to	the cause of death?
s,	uires 1 n sign Ild be	g p	chronic k	chey de	isev	ze,	Stage	5		1 🔼	Yes 2	No 3□Pr	obably 4 🗌 Unknown
orc	w request specifications	plet		O						24a. Was		24b. Were aut	opsy findings available
3ec	The lar	Completed								autor perfo	rmed?	death?	ompletion of cause of
<u>a</u>	ian: 1 ertifica ctor, p		25. Was case referred to medical examiner?				26. 1	Place of Deat	th <i>(Check</i>		2 <b>A</b> NO	1 🗆 163	2 - 110
<u> </u>	hysic his ce Il direc	욘	1 ☐ Yes 2 ☐No			R/Outpatient	3 □ DOA Ot	ther: 4 🗆 Nu	rsing Ho	me 5 Resid	dence 6 🗆	Other (Specia	fy)
οſ	ling P 1. After t uners	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of inju (Month, Da	iry 28 y, Year)	Bb. Time of injury		rk?	- 1	28d. Describe h	ow injury o	occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	t be	un. At home	a form atrac		☐ Yes 2 ☐	_	206 1 11 15			
ĕ	after after Direct		4 Homicide determin	building, etc	c. (Specify)	e, iarm, stree	n, lactory, office	7		28f. Location (S City or Tow		Number or Run	al Route Number,
	spita hours neral d fillec	Medical	29a. Certifier 1 <b>☐ Certifying P</b>	hysician: To the best of	my knowled	ge, death oc	cured at the time	ne, date and p	olace, and	d due to the car	use(s) and	manner as stat	ted.
	he Ho in 24 he Fu pleter	Med	(Check 2 \(\sumeq\) Medical Exa	miner: On the basis of e urse Practioner: To the	xamination a	nd/or investig	ation, in my opir	nion, death oc	curred at	the time, date a	nd place, a	nd due to the c	ause(s) and manner stated,
-	with To th		29b. Signature and title of certifier	Mit	1 1.	^	29c. Licen	se number	0.3		29d. Date	signed (Month,	Day, Year)
	)		1 /2 C			د	6	700	t 3		Dece	enter	12,2010
V.1			30. Name and address of person when PAUC U. A	o completed cause of d	eath (Item 23	3a) (Type, Pri	nt)	often S	4.	EASTE	n. 1	N 2	12, 2010 160/
KE	Stat	<u> </u>	31. Date filed (Month, Day, Year)	32 Registra	ar's Signatu	/ 3/	4	1			/		/
_	Registra	~	DEC 1 4 2	010	V A.	1 gar	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SCHEFER Month Physician/ RIAM 1930PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL MONTGOMERY MONTGOMERY GENERAL DLNEY If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) March 02 9. Birthplace (State or Foreign Country) New York **Funeral** 1 □ M 2 🎗 F Director 089-16-8681 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 U.S.A 15301 Beaverbrook Court, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Caucasian 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel Safron Rose Zobler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #109. NW, Washington, DC 20036 1727 Mass. Fred Schefer - Son Aue., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Olney, Maryland Judean Memorial Grdns 12/13/2010 Donation 5 Other (Specify) signature of Fundal Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M007.09 11800 New Hampshire Ave., Silver Spring, MD 20904 23a Part 1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediat cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY 1 Yes 2 No 3 Probably 4 Vinknown STENUSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 ( No Hospital: Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 5  $\square$  Pending 1 Natural Investigation Accident Suicide 6 Could not be 28e, Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D59418 DECEMBER

State

Registrar

MONTGOMERY GENERAL HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14 2010

O LUYEM [S] 31. Date filed (Month, Day, Year) ADEWUNMI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:50 p M 8\_ 2010 Anna Elizabeth Schmidt December /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Country Companions Assisted Living Tanevtown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 □ M 2 🛣 89 Maryland 215-09-1388 Director Feb 4, 1921 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h Counts 10a State 28a-f show 1 ☐ Yes 2 No traumatic event, the Medical Exertimen must be notified. Director Maryland Carroll Keymar 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 21757 2070 Keysville-Bruceville Road USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or items 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white à 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) Clothing Factory Seamstress marked other 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 17. Father's Name (First, Middle, Last) Be Elizabeth Mae Redmond James G. Parsley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any Injury or other trau. 2070 Keysville-Bruceville Road, Keymar, MD 21757 Anna B. Moffitt, Niece-in-law 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Keysville Union Cem. 12/13/2010 Keysville, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 136 E Baltimore St, Taneytown, MD 21787 Approximate Interval Between and Death 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Immediate Cause (Final Physician nous reburia disease or condition resulting in death) /Medical Due lo (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Examir burial-transi and Due to (or as a consequence of) attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2. ♣No 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown cate has been si page 2 should i Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No certificate 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Toth Assisted Living Hospital: 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending P after death. I Director: After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Hospital o 24 hours aff e Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who

(Item 23a) (Type, Print)

Pode Rl, Wastinmaler

			Please	State of Ma							0010	11100
	-		For State	State of Ma	ıryıan	•			ina ivientai r	iygie	ne Z U I U	41493
			Registrar  1. Decedent's Name (First, Middle, Last)			Cer	tificate of L	Jean	2. Date of	Reg	. No.	
	Physicia Medic		Wagne A	shton	8	neth			Month	S S	Day Year	3. Time of Death
,	Examin	er	4a. Facility Name lif not institution, give st Howard Cou	nty Ger	001	Honn	4b. City, Town, or	r Location of	f Death		4c. County of Deat	
	Funeral		5. Social Security Number 6. Sex			st birthday)	If Under 1 Year	If Under 2		Birth	1	
	Director		220-42-2215 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	ÍM 2 □ F	6	Yrs.	Months Days	Hours	Min. (Month,	Day, Ye	ar) (943 Co.	thplace (State or Foreign untry) MD
	fand shov	tor	10a. State 10b. County		10c. City	, Town or Loc	cation					10d. Inside City Limits
	Mary 28a-1 totifie	irec	MD Howar	rd			Mt. Ai	.ry				1 ☐ Yes X☐ No
	with the s 23a or ust be r	Funeral Director	10e. Street and Number 16119 Patapsco (	Overlook (	Ct.		10f. Zip Code 2177	1		10g	. Citizen of What Co USA	•
	death item: ner m			12. Was Decedent Ev Armed Forces?			Vas Decedent of H	ispanic Orig	in? (Specify Yes or I Puerto Rican, etc.)	10-	14. Race - Ame	
Maryland 21215-0036	per iff. Page 1 and 2 should be filed within 72 hours after death with the Maryland Drog artment of Health and Mental Hygiene. Drog rature of State 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	1 Never Married 2 Married 3 Widowed 4 🗓 Divorced	1 Ty Yes 2 ☐ N If Yes, Give Year or Dates.	lo		☐ Yes 2 👿 No				Black, White	nite
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ylar	ld be f Menta arked aric ev	욘	John Henry Smit	:h					Edna Fran	ces	Foster	
Nar	shou rand raum		19a. Informant's Name/Relationship (Type	, ,		1	-				y or Town, State, Zip	*
e,	and 2 Health em 27 ther t		Dr. Noah A. Smith	(Son/Exec	7	• •	28 Darlin	gton .		-	gh, PA 15	
Baltimore,	age 1 int of l t: If its		1 💢 Burial 2 □ Cremation 3 🕅 R		CE	emetery, crem	natory or other plac		Date 12/9/2010	- 1	c. Location - City or	
ij	artme artme ortan injun		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licenses		Nat		. Name and Addres				11s Churc	& CHAPEL, PA
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9	ate be physic the bi	edic	d d	l								
89	ding	N/M	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of	f <u>pr</u> egnar	ncy					23d. Date of del	livony
SOX.	eath c atter d for u	Physician/Medi	in the past 12 months?  1  Yes 2  No	1 Live Birth 2 4 Pregnant at			Ectopic pregnand Other (specify)	y		_	Month	Day Year
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<u>~</u>	n; Ihe ificate or, pa		25. Was case referred to medical				26 DI	acc of Dooth	1 🗆 You (Check only one)	es 2 🗹	No 1 ☐ Yes	2 □ No
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of	ng Phy ter thi neral		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of injury (Month, Day,		28b. Time of injury	28c. Injury work	/ at			njury occurred	
<u>o</u>	tendir eath. or: Af the ful	ifica	2 Accident Investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,,		Yes 2 🗆 I	No			
Division of Vital Records, P.O. Box 6876	Io the Hospital or Attending Physician: The law requires that the death certificate, within 24 hours pire during the within 24 hours after this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	l Certificate:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and City or Town, State)								ral Route Number,	
	e Hospi 24 hou e Funer eleted fill	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine only one) 3 Certifying Nurse	er: On the basis of exa	mination	and/or investi	gation, in my opinic	n, death occ	curred at the time, da	te and pl	ace, and due to the o	ause(s) and manner stated.
÷	No the company of the	~	29b. Signature and title of certifier	۸		3-, 4	29c. License			29d.	Date signed (Month	, Day, Year)
	WIL		Mondo	and							ec 5 Lol	
	10		30. Name and address of person who con	npleted cause of dea	ath (Item	23a) (Type, Pr	rint) 5755 HC	CEDAR Cul-1	Colur	nh	sia, Mi	> 21044
	Stat Registra		31. Date filed (Month, Day, Year)	32. registrar	s Signatu	ire	re Ned					· · · · · · · · · · · · · · · · · · ·

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 11 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 December 19:50 P M Kenneth L. Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Southern Maryland Hospital Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Feb. 10 1 **№**M 2 □ F Days Hours Min. 62 Director 578-64-0705 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Brandywine Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20613 United States 13219 Poppy Hill Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black White etc. þ 1 Never Married 2 4 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: African Completed 3 Widowed 4 Divorced American permit. Page 1 and 2 should be filed within 72 houn Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Rusiness Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Self-Employed Public Adjuster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Bennett Exum L. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13219 Poppy Hill Court Brandywine, Md. Wanda A. Smith - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State December 17 4 ☐ Donation 5 ☐ Other (Speçify) Ft. Lincoln Cemetery Brentwood, Maryland nature of Fune | Service | e 22. Name and Address of Facility Stewart Funeral Home, Inc. Cell 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or second. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav 1 Yes 2 No s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Winknown this certificate has been ral director, page 2 shoul 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 2 🗌 No 1 Yes Be completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital 2 No Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examiperion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place and due to the cause(s) and manner as stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month. Day, Year) of death (Item 23a) (Type, Print) a 31. Date filed (Month, Day, Year, 32. Registrar's Signature State back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12/12/2010 6:45 P CARL J. SCHAEFER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 700 PORT ST., APT. 104 **EASTON** TALBOT 5. Social Security Numbe If Under 7. Age (In vrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 🛛 M 2 🗆 F Months Days Hours Min (Month, Day, Year) 4/27/1920 NEW YORK Director 050-12-3875 90 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No MARYLAND TALBOT **EASTON** 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 21601 700 PORT ST., APT. 104 items ; 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. ò ğ 1 Never Married 2 M Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", Specify Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **PROFESSOR EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fil of Health and Mental fitem 27 is marked မ CARL J. SCHAEFER, SR ISABEL SHEAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 PORT ST., APT. 104, EASTON, MD 21601 JOANN SCHAEFER / WIFE Baltimore, 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
MID SHORE CREMATION CENTER BY 9 1 Burial 2 X Cremation 3 Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) 12/14/2010 CAMBRIDGE, MD COLLEEN CURRAN-BROMWELL, P.A 21. Signature of Funeral Sc 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine and -transit Cause (Disease or linjury Hospital or Attending Physician; The law requires that the death certificate be executed that initiated event resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical P.O. Box 68760 use as IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ξō in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🖼 o 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 this certificate has autopsy performed? Yes 2 No 1 Yes 2 Ano ne Hosp....
iin 24 hours after death.
the Funeral Director: After this certificate
. elval in by the funeral director, pc 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Hospital: 2 No Other: 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Sesidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred injury 5 Pendina work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after de To the Funeral Directo completed filled in by th Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registraris Signature State Registrar

3. Time of Death

7:00P M

DEC. 19 Day 010 Year

**Physician** /Medical **Examiner Funeral** Director r then "natural", or Iteme 23a or 28a-f ehow Ite Medical Examiner must be notified at Director Funerai Baltimore, Maryland 21215-0036 þ Completed Hygiene. and Mental Hygie traumatic event, permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: It Item 27 Is marked oth eny lightly or other traumatic event 200s.

ORPHA JOSEPHINE SILER

**Physician** /Medical Examiner

physicien and s the burial-transit The law requires that the daath certificate be executed the attending | use as signed by the aid be detached for peen page 2 s certificate Attending Physician: director this After thi death. Director: / within 24 hours after To the Funeral Dire ŏ

P.0.

Division of Vital Records,

To the Hospital

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CHARLES CO.NUR.& REHAB.CENTER LA PLATA CHARLES 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Hours 1 □ M 2 🕁 F Days 288-34-7029 85 6-6-1925 W.VA. Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits MD -CHARLES LA PLATA X□Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10200 LA PLATA ROAD 20646 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE 3√ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE 12 HOSPITALS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIS HOWARD WHITE MACEL JORDAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH SCHOUTEN-DAUGHTER 4130 CLYDE LANE WHITE PLAINS, MD. 20695 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State | Burial 2 Departion 3 Removal from State | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial Properties | Commercial RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Fundaral Service Licensee MO0479 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebra Due to (or as a consequence of): atherosclerosis ardio vaso Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20/2010

State Registrar

DHMH 17 Rev 1/2001

30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print)

USSein.

32. Registrar's Signature

1000

31. Date filed (Month, Day, Year)

5 DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec. 14. 2010 3:45 P Frank Tresente, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, aug. 2, 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Min. Country) Newark Director 156-24-4228 75 Aug. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1X Yes 2 □ No Prince George's Colmar Manor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3404 40th Place 20722 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 ☑ Yes 2 ☐ No 1953 Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ental Hygiene. ked other than "natural", c c event, the Medical Exam 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Completed 1957 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Specialist US Postal Service marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Frank Tresente, Sr. Mary M. Weichel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3404 40th Place, Colmar Manor, MD 20722 Patricia E. Tresente - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/20/10 Resurrection Cemetery Clinton, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fundal Service pansee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

Jo the Funeral Director, After this certificate has been signed by the attending physician and completed filed in by the Inneral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an performed' 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🔲 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060100 12-15-10

State

Registrar

BLVD

32. Registrar's Signature

Allmin A Silva Shrip

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UniversIr

31

31. Date filed (Month, Day, Year)

7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 41499

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Physici dical Exami			2. Date of Death  Month December 11	y Year I. 2010	3. Time of Death 0325 hrs
The same of the sa		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death 8814 Hawthorne Lane  Laurel		4c. County of Death Prince George	
Funeral Director		5. Social Security Number 220-98-1723  6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24Hrs Months Days Hours Min		Co	thplace (State or Foreign untry) <b>Cheverly</b> , aryland
d tow any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Prince Georges Laurel			10d. Inside City Limits 1 X Yes 2 No
vith the Maryland 123a or 28a-f show 10otified at ooce.	Director	10e. Street and Number 10f. Zip Code 20708		Citizen of What Cou	
leath with the items 23a	Funeral I	11. Marital Status 1 X Never Married 2 Married 2 Married 1 Yes 2 X No	pecify Yes or No-		can Indian, Black,
iours after d atural", or xaminer m	ģ	3 Widowed 4 Divorced If se, Give Year 1 Yes, 2 X No specify:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of valuing most of working life. DO NOT use retired.		Specify: B1:	
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she e event, the Medical Examiner must be notified at occe	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  10th grade Unemployed	e (First, Middle, Maid	None	
the Figure	Be C		Jeanine		
2121 ould be fi d Mental I s marked iie event,	To E	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or I	Rural Route Number	, City or Town, State	, Zip Code)
and 2 sho and 2 sho fealth and item 27 is traumati		Maria Rena Julien (Aunt) 9551 Muirkirk Road;L		yland 207 c. Location - City or	
1 E E E		4 Donation 5 Other Specify: Maryland National Memoria	.17,2010 11 Park   L	aurel,Mar	yland
Balt permit. Depart Import injury		21. Signature of Funeral Service Liberisee  22. Name and Address of Facility R.  Inc.; 600 Kennedy S  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	treet,N.W	.: Washing	
Physician //Medical		failure. List only one cause on each line.	or respiratory arrest, s	snock, or neart	Between Onset and Death
≟xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):			
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated counts coulting in death), lest consistent of the country of th			
760, cate be executed physician and the burial - transit	I Exa	events resulting in death) Last			
60, ate be exe hysician a e burial -	dica	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy			
Aecords, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	Physician/Me	2   Fetal death   3   Ectopic pregnal to the past 12 months?   4   Pregnant at time of death   5   Other (Specify)		23d. Date of delivery Month [	day Year
that the deaned by the a		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
F.O. ires that the signed by d be detach	d by		1 Yes 2	No 3 Prot	ably 4 Unknown
of Vital Records, P.O og Physiciae. The law requires that the this certificate has been signed by nearl director, page 2 should be detax	Completed		24a. Was an autopsy performed	prior to d	topsy findings available ompletion of cause of
	Be C	25. Was case referred to medical 26.Place of Death (Check	only one)		
of Vitiog Physici og Physici After this c	ToE	Yes Z No	ng Home 5 Res		: Scene
E i t g	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury April 28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe how Subject was sh	ot	
Division the Bospital or Attendic hin 24 hours after death. the Funeral Director: A npletely filled in by the fu	Certification	3 Suicide 6 Could not be determined (Specify) Other (specify): In car	or Town, State 8814 Hawthorne I	Lane, Laurel, MD	ral Route Number, City
Division To the Hospital or Atterwithin 24 hours after dea To the Funeral Director	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	at the time, date and	place, and due to th	e cause(s)
2	2	29b. Signature and title of certifier  29c. License number  O.C.M.E.		d. Date signed (Moi ecember 11, 20	
		30. Name and address of person who completed cause of death (Item 23a)			
a. R.		Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 23  31. Date filed (Month, Day, Year)  82. Registrar's Signature	1201		
St Regis	tate trar	DEC 1 7 2010 Augus B. Laure			

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donna Lynn Todd December Medical 2010 0845 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 128 Meadow Hall Road E1kton Ceci1 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months 1 □ M 2 🗓 F Days Hours Director April II. Year 964 219-80-3354 Maryland Usual Residence of Decedent I Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits Maryland Ceci1 E1kton 1 🗆 Yes 2 👿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 Meadow Hall Road 21921 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give þ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Payne Beulah Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Heather Todd/Daughter 588 Old Telegraph Road, Warwick, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State December 29, 2010 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Pu sician/ Medical Immediate Cause (Final Lung Cancer Onset and Death disease or condition resulting in death) Due to (or as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events.) Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h completed filled in by the funeral director, page performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Jospital C.
4 hours after dea..
-val Director: After 5 Pending injury ☐ Accident Investigation 6 Could not be 1 Yes 2 No Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, D 32. Registrar's Signature State

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Registrar